AD-A137 516 HOSPITAL MERGER INCREASED MEDICARE AND MEDICAID PAYMENTS FOR CAPITAL COSTS(U) GENERAL ACCOUNTING OFFICE WASHINGTON DC HUMAN RESOURCES DIV 22 DEC 83 1/2

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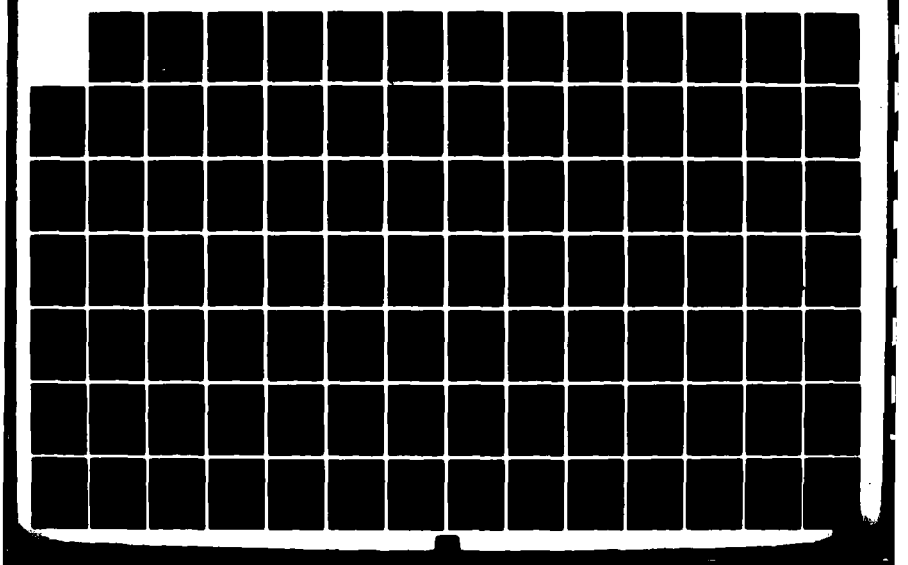

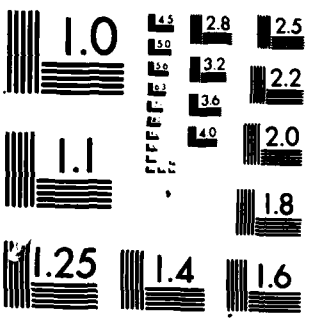

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BY THE COMPTROLLER GENERAL

Report To The Honorable Willis D. Gradison, Jr. House Of Representatives

OF THE UNITED STATES

Hospital Merger Increased Medicare And Medicaid Payments For Capital Costs

In 1981, the Hospital Corporation of America (HCA) acquired the assets (54 hospitals, 18 nursing homes, and other subsidiaries) of Hospital Affiliates International, Inc., from INA Corporation. INA received $425 million in cash and 5.39 million shares of HCA stock valued at $190 million. In addition, HCA assumed long-term debt of about $270 million.

During the first year after the acquisition, the overall costs of the acquired hospitals increased because of the acquisition by a net amount of about $55 million attributable to changes in interest, depreciation, and home office expenses. A portion of the increased costs was allocated to the Medicare and Medicaid programs.

In accounting for cost items associated with the acquisition, HCA used a number of methods that GAO questions under Medicare reimbursement principles (which are also generally used by Medicaid). These methods generally increased the amount claimed for reimbursement under Medicare and Medicaid.

GAO/HRD-84-10
DECEMBER 22, 19

COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON D.C. 20548

B-213674

The Honorable Willis D. Gradison, Jr.
House of Representatives

Dear Mr. Gradison:

In accordance with your request, we reviewed the changes in hospital costs resulting from the Hospital Corporation of America's (HCA's) acquisition of Hospital Affiliates International, Inc., from INA Corporation. We focused on changes in interest, depreciation, and home office costs resulting from the acquisition. This report also discusses a number of methods HCA used in accounting for cost items associated with the acquisition which we question under Medicare reimbursement principles. The methods used generally increased claims for Medicare reimbursement.

Comments received from HCA, the Department of Health and Human Services, and the Blue Cross-Blue Shield Association were considered in finalizing the report. This report contains recommendations to the Secretary of Health and Human Services.

As arranged with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time we will send copies to interested parties and make copies available to others upon request.

Sincerely yours,

Charles A. Bowsher

Comptroller General
of the United States

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COMPTROLLER GENERAL'S
REPORT TO THE HONORABLE
WILLIS D. GRADISON, JR.
HOUSE OF REPRESENTATIVES

HOSPITAL MERGER INCREASED MEDICARE AND MEDICAID PAYMENTS FOR CAPITAL COSTS

D I G E S T

Representative Willis D. Gradison, Jr., asked GAO to determine the effect on health care costs of the Hospital Corporation of America's (HCA's) acquisition of the assets of Hospital Affiliates International, Inc. (HAI), from INA Corporation. GAO was asked to use this acquisition as an example of what happens to costs when hospitals change ownership.

This report focuses on changes in interest expense, depreciation, and corporate-level management expense (home office expense) because these costs are most likely to change significantly as the result of an acquisition. Normally, when acquiring an operating hospital, the new owner records the value of the acquired assets in its books at a higher amount than carried in the previous owner's books. This occurs because the purchaser usually pays more for the acquired hospital than its depreciated book value. Therefore, depreciation expense, which is related to book value, increases even though the acquired assets themselves are not altered.

Also, when acquiring an operating hospital the purchaser frequently borrows funds to cover a substantial portion of the purchase price, which in turn often results in higher interest expense than incurred by the previous owner.

The increased capital expenses noted above (interest and depreciation) may be at least partially offset by decreases in operating costs, if the new owner is more efficient than the previous one.

GAO reviewed the costs associated with the acquired hospitals before and after acquisition from two perspectives. The first perspective focused on the increased costs based on HCA's corporate records because such increases could affect all hospital payors. The second perspective used the Medicare principles of reimbursement because these are the standards used nationwide by the government to judge the allowability and reasonableness of hospital costs. Also, states normally use Medicare principles or ones very similar to them for Medicaid reimbursement purposes.

To assess the effect of the acquisition on costs per patient day, GAO also evaluated changes in costs at two specific hospitals. To do this GAO used Medicare cost reports submitted by the individual hospitals and by the HCA and HAI corporate offices as well as HCA and HAI corporate accounting records. These were the records used to claim Medicare and Medicaid payment. GAO did not verify the accounting records to source documents.

The exact effect of HCA's acquisition of HAI on Medicare's costs has not been determined because program officials have not decided what amount of increased capital costs they will allow.

HOSPITAL CAPITAL COSTS WERE HIGHER AFTER THE ACQUISITION

On August 26, 1981, HCA purchased HAI's assets, which consisted of 54 hospitals, 18 nursing homes, at least 10 medical office buildings, and 42 other corporate entities such as hospital management companies. HCA paid INA $425 million in cash (which HCA borrowed) and 5.39 million shares of stock valued at $190 million by HCA. In addition, HCA assumed HAI's debt of about $270 million. (See p. 3.)

HCA later sold all of the acquired nursing homes to Beverly Enterprises for about $11.5 million and 1.1 million shares of Beverly stock valued at about $23.2 million. Beverly also assumed about $8 million in debt associated with the nursing homes. HCA has also resold some of the hospitals it acquired from HAI. Because GAO's review focused on hospital costs, it did not review the effect on the costs of the nursing homes involved in the acquisition or of the resale of hospitals.

GAO's analysis of HCA's corporate records showed that, during the first year after the acquisition, the 54 acquired hospitals' costs increased by about $55 million. This resulted from increased interest expense due to borrowing to finance the acquisition and increased depreciation expense because assets were revalued upward after the acquisition. These increases were partially offset by a decrease of $15.7 million in home office costs.

GAO estimates that overall interest costs increased by about $62.5 million, nearly tripling. (See p. 8.) In addition, depreciation on the hospitals and the medical office buildings increased by about

$8.4 million per year, almost 90 percent, as a result of HCA's revaluing these acquired assets. (GAO included medical office building costs in its depreciation analysis because these costs could not be segregated from the costs of the hospitals.) (See p. 10.) Based on information from HCA officials and unaudited home office cost reports, the estimated home office cost savings for the first year were about $15.7 million. Officials said that the savings resulted from an overall reduction in home office staffs and home office costs being spread over more hospitals. (See p. 11.)

In summary, interest expense increased about $62.5 million and depreciation expense increased about $8.4 million, for a total increase of about $70.9 million. Home office costs decreased by about $15.7 million, resulting in a net increase of about $55.2 million for these three cost items.

HCA believes that substantial savings will be realized through management improvements it instituted at the acquired hospitals, and it estimated these savings in a report to the Department of Justice before the acquisition. That report cited such items as lower supply costs through increased volume of purchases and decreased data processing costs through better contracting. GAO could not evaluate these claimed savings because, among other reasons, the report lacked the necessary details. According to HCA officials, they could not quantify the savings at the time of GAO's fieldwork for a number of reasons, and quantification in the future would be extremely difficult. (See p. 13.)

EFFECT ON COSTS PER PATIENT DAY AT TWO HOSPITALS

To measure the effect on Medicare and Medicaid costs, GAO allocated HCA's claimed costs for depreciation, interest, and home office expenses to those two programs for two hospitals identified by HCA. (See p. 13.) GAO estimated that for the year following the acquisition:

--The overall increase in costs due to changes in these three items was about $1 million at one hospital and $300,000 at the other.

--The portion of these increases allocated by HCA to Medicare and Medicaid was $465,000 at one hospital and $117,000 at the other.

--The per patient day increase in Medicare costs shown in HCA's cost reports as a result of these changes was about $26 and $21, respectively.

--The per patient day increase in Medicaid costs shown in HCA's cost reports as a result of these changes was about $31 and $27, respectively.

QUESTIONABLE HANDLING OF COST ITEMS FOR MEDICARE REIMBURSEMENT

GAO reviewed the procedures HCA used for Medicare cost reporting purposes to allocate interest to the acquired hospitals and to value the acquired assets and compute depreciation on them. Reviewing these matters using Medicare's principles of cost reimbursement (which are also generally used by Medicaid), GAO questioned a number of HCA's methods.

HCA based its position on its interpretation of Medicare policies and on Generally Accepted Accounting Principles (GAAP), which are designed to provide rules for reporting the financial position, results of operations, and changes in the financial position of an entity for present and potential investors and creditors. Although GAAP normally represents the appropriate principles for financial reporting purposes, these principles are not always appropriate for a cost reimbursement system such as Medicare uses. Under Medicare, GAAP can be used only in those instances when Medicare's principles of reimbursement do not cover a situation.

The HCA methods that GAO questioned would tend to increase the amount of Medicare payments to the hospitals (and also increase Medicaid payments because Medicaid generally uses principles very similar to Medicare's). Medicare's paying agents have not yet determined the amount of increased costs the program will allow, and they may disallow the items GAO questioned when a final determination of the hospitals' allowable costs is made. Specifically, HCA used the following methods that GAO questioned:

--HCA allocated debt and related interest to Medicare using a method different from the one prescribed by the program. This resulted in higher capital costs being allocated to Medicare. (See p. 18.)

--HCA discounted the debt assumed from HAI that bore interest rates below market rates at the

time of acquisition. The effect of discounting was to increase the amount of interest claimed from Medicare. (See p. 25.)

--HCA assigned inaccurate values to the real assets because of inconsistent practices in the appraisal and depreciation processes. Specifically, (1) useful lives used in appraising the acquired assets were different from the Medicare-approved lives used in depreciating them, (2) acquired assets were assumed to have no salvage value when depreciation was calculated, and (3) values were assigned to leased assets that resulted in higher interest and depreciation expenses being claimed. In addition, the appraisals' independence and accuracy are questionable because the appraised values were changed at HCA's request. This change would have the effect of increasing the assets' value by $28.2 million above the value that would have been computed using Medicare-approved useful life estimates. (See p. 26.)

CAPITAL COSTS ARE CURRENTLY PAID ON A COST BASIS UNDER MEDICARE'S PROSPECTIVE PAYMENT SYSTEM

The Social Security Amendments of 1983 changed the method of payment for Medicare inpatient hospital services. Under the old law, the payment amounts were based upon hospitals' reasonable costs. Under the 1983 amendments, the payment amount is determined prospectively for each discharge. The new payment system is being phased in over a 3-year period starting with each hospital's first cost reporting period beginning on or after October 1, 1983.

Under the new system, savings in operating costs can be retained by the hospitals; however, capital expenses, such as interest and depreciation, are specifically excluded from the system until October 1, 1986. During this period, capital expenses will continue to be reimbursed on a reasonable cost basis. After October 1, 1986, capital expenses will no longer be excluded from the prospective payment system if a method acceptable to the Congress for including these costs is found.

Because hospital capital costs will continue to be paid on a reasonable cost basis for at least 3 more years, because other hospital acquisitions are

likely, and because in GAO's opinion HCA misinterpreted Medicare policy related to handling acquisition costs, GAO is making recommendations to the Secretary of Health and Human Services to clarify Medicare guidelines to help assure that changes in costs associated with future hospital acquisitions are handled consistent with Medicare policy. GAO is also recommending that the Medicare claims paying agents consider GAO's findings before finalizing payments to the hospitals acquired by HCA.

AGENCY AND HCA COMMENTS

The Department of Health and Human Services (HHS) commented that the Medicare claims paying agents will consider GAO's findings in finalizing payments to the acquired hospitals. HHS and the Blue Cross and Blue Shield Association (Medicare's claims paying agent for most of the hospitals involved in the acquisition) said they had not finalized their position on the issues GAO raised. HHS also said it is reviewing its operational guidelines and will clarify them in light of GAO's findings.

The Blue Cross and Blue Shield Association also said that its research in many of the areas GAO raised was not as conclusive on the scope and clarity of Medicare policy as GAO suggested. While GAO believes its conclusions regarding the application of Medicare reimbursement principles are correct, GAO agrees with the Association that the principles' application could be clarified. That is why GAO is recommending that HHS clarify its guidelines in these areas.

HCA generally disagreed with GAO's findings. It believes it has correctly claimed reimbursement from Medicare in accordance with the program's policies for the depreciation and interest costs associated with the acquisition of HAI's assets. GAO believes, however, that HCA has misinterpreted Medicare reimbursement policy and that the questions raised concerning the costs claimed are appropriate. HCA's comments regarding its treatment of costs and GAO's analysis of them are discussed in detail in the report and in appendix VI.

Contents

ABBREVIATIONS

AHA	American Hospital Association
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
HAI	Hospital Affiliates International, Inc.
HCA	Hospital Corporation of America
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services

CHAPTER 1

INTRODUCTION

Representative Willis D. Gradison, Jr., wrote to us expressing his concern about the current policy toward reimbursement of hospital capital expenses. He asked us to review a major acquisition of hospitals by a corporation as an example of what effect such transfers can have on Medicare, Medicaid, and private hospital payors. Specifically, he asked us to look at the Hospital Corporation of America's (HCA's) acquisition of the assets of Hospital Affiliates International, Inc. (HAI), from INA Corporation to determine how much costs would increase because of the acquisition.

We reviewed the costs associated with the acquired hospitals before and after the acquisition from two perspectives. The first perspective focused on the increased costs based on HCA's corporate records because such increases could affect all hospital payors. The second perspective used the Medicare principles of reimbursement because they are the uniform hospital cost reimbursement principles the government uses to judge the allowability and reasonableness of hospital costs and how such costs are allocated to Medicare. In addition, states generally use principles very similar to Medicare's when establishing hospital payments for the Medicaid program. Furthermore, Medicare represents the largest single source of payments to hospitals and is the government's largest hospital reimbursement program. Finally, we have access to records and Medicare data under the Social Security Act.

We concentrated our review on three types of costs--interest, depreciation, and home office--because they are most likely to be affected significantly by an acquisition. Also depreciation and interest represent the vast majority of hospital capital expenses.

Another item that Medicare pays as a "cost"--return on equity capital--could also be affected by an acquisition by proprietary providers. Equity capital is defined as the provider's investment in plant, property, and equipment related to patient care plus net working capital maintained for necessary and proper operation of patient care activities. At the time of the acquisition, Medicare paid proprietary providers a rate of return on equity capital equal to 1-1/2 times the rate earned on funds invested by Medicare's Hospital Insurance Trust Fund. The Social Security Amendments of 1983 changed the rate of return so that it now equals the rate earned by the Trust Fund. If an acquisition resulted in an increase or decrease in equity capital, return on it would correspondingly change. We did not review in

detail whether Medicare's total return on equity capital payments changed as a result of the acquisition because this would have required us to review all provider cost reports for HAI and HCA. HCA used stock to pay about 20 percent of the purchase price of the acquisition, and this would qualify as equity capital under Medicare rules.

MEDICARE CAPITAL EXPENSES REIMBURSEMENT PRINCIPLES

Medicare, authorized by title XVIII of the Social Security Act (42 U.S.C. 1395), is the federal program that pays for health care services received by almost all Americans age 65 and over and some disabled persons. Until fiscal year 1984, Medicare reimbursed each hospital its actual allowable costs of providing services to eligible persons up to a predetermined maximum amount that was based on the average costs of similar hospitals. For cost reporting periods beginning on or after October 1, 1983, general acute care hospitals will be paid based on Medicare's hospital prospective payment system (included in the Social Security Amendments of 1983, Public Law 98-21). This system, which bases payments on the average cost of hospitals for particular groups of related diagnoses, is being phased in over a 3-year period. However, hospitals' capital costs are treated separately under both Medicare's cost reimbursement and prospective payment systems.

Capital costs are those facility costs associated with furnishing the buildings and equipment necessary to provide patient care. Allowable capital costs under Medicare include depreciation for these assets and interest paid on funds borrowed to acquire them. Under the cost reimbursement and prospective payment systems, capital costs are passed through; that is, they are not used in computing the maximum payable amount under cost reimbursement or in establishing the prospective rate and are paid to the facility on an actual reasonable cost basis. Thus, Medicare will generally pay the percentage of capital costs that reflects the ratio of Medicare utilization to total utilization. The prospective payment law requires the Department of Health and Human Services (HHS) to report to the Congress within 18 months of enactment on the methods, along with proposals for legislation, by which capital-related costs associated with inpatient hospital services can be included in the prospective payment system. If a method acceptable to the Congress is found, capital costs will be included in the payment rates beginning October 1, 1986.

Under Medicare's cost reimbursement principles, depreciation on the assets used to provide patient care is normally required to be computed based on the acquisition cost of an asset less its salvage value, using the straight-line method over the asset's

estimated useful life. Interest expenses on loans used to acquire assets used in providing patient care are reimbursed at cost, assuming the loan was necessary (that is, the provider had insufficient funds for outright purchase), the interest rate is reasonable, and the loan is not from a party related to the provider by common ownership or control. If a provider leases assets, it is allowed to claim the cost of the lease to the extent this amount is reasonable.

Medicare law, regulations, and guidelines include an extensive set of procedures--referred to as Medicare principles of cost reimbursement--for determining the allowable amount of capital (and other) costs that will be recognized by Medicare for reimbursement. If a situation arises that is not covered by the Medicare principles, providers are permitted to account for it using Generally Accepted Accounting Principles (GAAP). GAAP is designed to provide rules for reporting an entity's financial position, results of operation, and changes in financial position for present and potential investors and creditors and other users. However, GAAP is not designed for the special purpose of determining costs that will be paid under a cost reimbursement system such as Medicare's.

Medicare contracts with insurance companies, such as Blue Cross and Mutual of Omaha, to determine the amount of Medicare payments individual hospitals will receive. These paying agents are called intermediaries. Each year hospitals submit cost reports to the intermediaries detailing hospital costs and allocating a portion of them to Medicare and Medicaid. The intermediaries have not yet finally determined how much of the costs associated with the acquisition will be recognized as allowable for the Medicare program.

DESCRIPTION OF THE PURCHASE

On August 26, 1981, HCA acquired HAI's assets from INA Corporation. In the transaction, HCA acquired 54 hospitals, 18 nursing homes, at least 10 medical office buildings, and 42 other corporate entities. The other entities included hospital management companies that were responsible for managing 102 hospitals, 2 insurance companies, and other corporations (some of which were inactive). HCA incurred about $6.5 million in legal and accounting fees, severance pay to employees who worked at the acquired entities, and other costs related to the acquisition. HCA paid INA $425 million in cash and 5.39 million shares of HCA stock that HCA valued at $190 million--or about $35 a share--based on

the stock exchange selling price of its stock.[1] HCA also assumed HAI long-term debt of $270 million, of which about $94 million was retired within 4 months of the acquisition.

On August 31, 1981, HCA signed a letter of intent to sell to Beverly Enterprises the 18 nursing homes acquired from HAI. Under the sales agreement, effective November 11, 1981, HCA received about $11.5 million in cash and 1.1 million shares of Beverly common stock valued by HCA at about $23.2 million. Beverly also assumed about $8 million in long-term debt owed by the nursing homes.

Determination of legal statutory mergers

Under Medicare regulations,[2] if there is a statutory merger (combination of two or more corporations with one of the corporations surviving), the assets of the merged corporation(s) may be revalued by the surviving corporation. Because the Health Care Financing Administration (HCFA) determined HCA's acquisition of HAI to have constituted a statutory merger, the acquired assets could be revalued for Medicare purposes. As a result HCA increased the book value of the hospitals and medical office buildings acquired from HAI by $272 million--from $258 million to $530 million.

HCA hired an appraisal firm to estimate the value of the land, land improvements, buildings, and building equipment for the hospitals, medical office buildings, and nursing homes acquired in the transaction. Based on these appraisals, HCA adjusted the individual accounting records for the assets. A few of the appraised values decreased from the book value recorded by HAI, but most of them increased substantially.

The Blue Cross Association, in its role as Medicare's prime contractor for administering payments to hospitals, reviewed documents relating to the acquisition. The Association said that, in its opinion, assuming that applicable state laws were followed, the documents evidenced a completed statutory merger within the meaning of Medicare regulations.

In March 1982, an official from HCFA's Bureau of Program Operations stated that, in HCFA's opinion, the transaction constituted a statutory merger, assuming applicable state laws were followed.

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[1]On the date of the sale, the price of the stock on the New York Stock Exchange closed at $37.75.

[2]42 C.F.R. 405.415(1)(2)(i).

CHARGES VERSUS COSTS

Because payors such as Medicare reimburse hospitals on the basis of allowable costs, the increases in the costs to the Medicare program can be identified because standards have been established regarding allowable costs. Also, states generally use the same standards for their Medicaid programs.

Where payors reimburse on the basis of charges (for example, commercial insurance companies and patients without insurance), HCA will determine the extent to which increased costs as reflected in its corporate accounting records will eventually be passed on in the form of higher charges. Competition in the various market areas and HCA's corporate philosophy will determine to what extent charges reflect costs. For these reasons, we were not able to address the percentage increases for charge-based payors.

HCA did give us examples of the extent of charge changes after the acquisition for selected items at two hospitals. At the first hospital, charges for a semiprivate room were 11.1 percent higher on January 1, 1982, than on the day of the acquisition, while aggregate charges for seven ancillary services[3] increased 9.6 percent. At the second hospital, charges for a semiprivate room were 13.8 percent higher on August 30, 1982, than on the day of the acquisition, while aggregate charges for 14 ancillary services increased 14.9 percent.

The charge increases over 4 months at one hospital and 1 year at the other are relatively close to the increase in hospital charges as measured by the Consumer Price Index's hospital and other medical services component for the year after the acquisition, which was 14.5 percent.

OBJECTIVES, SCOPE, AND METHODOLOGY

As requested by Representative Gradison, we used the HCA acquisition of HAI as an example of changes in hospital costs under current policies for reimbursement of hospital capital expenses after a change in ownership. We were asked to determine (1) whether the cost of hospital care for Medicare, Medicaid, insurance companies including Blue Cross, and private patients increased; (2) what percentage of the increase for each of these

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[3]Services provided to patients in addition to routine services (room, board, and general nursing), including X-rays, laboratory tests, and physical therapy.

groups can be attributed to the acquisition; and (3) how much the cost per patient day for each group increased. For the reasons stated on page 5, we were not able to address the percentage increases for charge-based payors, such as insurance companies.

We directed our review at changes in interest, depreciation, and home office expenses at the acquired hospitals and medical office buildings because these costs are most likely to change significantly as the result of an acquisition. We included the medical office buildings in our analysis because costs for them in some cases could not be segregated from the costs for the hospitals. In any event, such buildings represented a small part (only 4 percent of the total appraised value) of the overall acquisition.

To determine the increase in interest cost, we estimated HAI's and HCA's interest expenses for the periods before and after the acquisition based primarily on information in their unaudited accounting records and Medicare home office cost reports. The periods covered were January 1 through August 26, 1981, and August 27, 1981, through August 31, 1982.

To determine changes in depreciation, we used the depreciation expenses in HAI's trial balance for the period January 1 through August 26, 1981, adjusted to an annual basis. For the period after the acquisition, we first identified for each hospital or medical office building the appraised values assigned to its land improvements, buildings, and building service equipment. We then divided the assigned value by the useful life HCA used for each of these assets. This value reflects the estimated annual depreciation after the acquisition.

Home office expenses before and after the acquisition were obtained from the Medicare home office cost reports.[4] Based on discussions with HCA officials, we deducted nonrecurring expenses from the figures shown in the cost reports.

Although we determined the merger's overall impact, we did not determine its full effect on each hospital's costs because of the many hospitals involved and because most of the individual hospitals had not filed cost reports at the start of our fieldwork. However, to determine the possible magnitude of the impact of the cost changes on individual hospitals and to respond to the request for cost-per-patient-day data, we reviewed two former HAI

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[4]Multihospital chains normally incur costs at the corporate headquarters which are allocated to the individual hospitals. Such headquarters costs, referred to as home office costs, must be reported to Medicare separately.

hospitals[5] that reported to HCA's Western Division Office in Nashville. Both hospitals had submitted Medicare cost reports after the acquisition. We computed the total change in reported costs resulting from increases in interest and depreciation and the decrease in home office costs. We also computed the Medicare and Medicaid cost increases for the same cost classifications. These hospitals' cost increases, however, may not be representative of all 54 hospitals acquired by HCA.

Information and data were obtained from HCA corporate and division officials and summary documents. We did not verify the data obtained to source documents. The documents we used reflected the actual data used to prepare Medicare cost reports and, therefore, to claim payment from the program.

We obtained comments on our approach and our estimate of increased costs from HCA, Blue Cross, and HCFA officials. We also obtained data and information from other intermediaries, such as Aetna and Mutual of Omaha.

The Medicare intermediary for the HCA home office, Blue Cross-Blue Shield of Tennessee, was still gathering data relating to the acquisition as of June 1983. The intermediary could revise HCA's allocation approach, which could change the amount of cost allocated to the Medicare and Medicaid programs. Also, the individual cost reports we used had not been audited and could change as a result of intermediary audits.

Our fieldwork, conducted between August 1982 and May 1983, was performed at the HCA corporate headquarters and its Western Division Office in Nashville, the Blue Cross and Blue Shield Association office in Chicago, Blue Cross-Blue Shield of Tennessee offices in Chattanooga and Nashville, and HCFA headquarters in Baltimore.

Written comments were received from HHS, the Blue Cross and Blue Shield Association, and HCA. The comments are included as appendixes IV, V, and VI, respectively. Appendix VI also includes our detailed analysis of HCA's comments.

Except as noted above, our review was performed in accordance with generally accepted government auditing standards.

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[5]Both hospitals were leased. HCA later sold its lease rights to both hospitals to another corporation.

CHAPTER 2

THE ACQUISITION WILL SIGNIFICANTLY AFFECT ALL HOSPITAL PAYORS

This chapter covers cost changes in interest, depreciation, and home office expenses resulting from the acquisition primarily as they were recorded in HCA's books and thus covers cost increases from a corporate standpoint. Our analysis shows that, during the first year after the acquisition, hospital costs increased by a net amount of about $55 million due to these items. HCA will have either to recoup these increased costs through increased revenues from hospital payors or to absorb the increases, which would result in decreased corporate earnings. Over the years the amount of increased interest expense will decline as the outstanding principal is paid, the amount of increased depreciation expense will remain constant for Medicare purposes because the program requires the use of straight-line depreciation, and long-term changes in home office expenses are not certain.

In addition, at two hospitals suggested by HCA, we reviewed the increases in Medicare and Medicaid costs per patient day due to changes in interest, depreciation, and home office costs. Cost per patient day for the first year after the acquisition increased because of these expenses by about $26 at one hospital and $21 at the other for Medicare patients and by about $30 and $27, respectively, for Medicaid patients. One of the reasons the average costs per day for Medicaid patients were higher was that their average lengths of stay were shorter and thus the ancillary costs were spread out over fewer days.

INCREASED INTEREST EXPENSE

We estimate that annual interest expense allocated to the assets acquired by HCA from HAI increased by about $62.5 million for the first year after the acquisition as follows:

	Annual interest (millions)
Under HCA ownership	$95.2
Under HAI ownership	32.7
Total increase	$62.5

About $270 million in HAI debt was assumed by HCA. In addition, HCA borrowed $425 million to finance the acquisition. Also, HCA allocated $30 million of its preacquisition home office debt to the acquired assets. In total, HCA allocated $595 million in debt as of January 1, 1982, to the acquired hospitals and medical office buildings:[1]

HCA new borrowings to finance acquisition	$425,000,000
HCA corporate debt allocated to the former HAI facilities	30,000,000
HAI corporate office debt assumed by HCA	55,857,993
Individual hospital debts assumed by HCA[a]	84,118,752
Total debt allocated	$594,976,745

[a]Also includes medical office buildings.

In addition to the debt that had been retired ($93.9 million), one reason the total of the assumed, new, and allocated preexisting debt ($725 million) did not equal the amount of debt HCA allocated to the assets ($595 million) is that HCA discounted the debt it assumed from HAI.[2] As a result, the assumed debt was recorded at a lower amount in HCA's books than in HAI's, and the interest allocated to the acquired assets increased. As of January 1, 1982, HCA had not paid off about $71.7 million in assumed HAI corporate debt and about $103.0 million in assumed debt recorded on the hospitals' books.[3] However, after discounting, HCA recorded in its books only about $55.8 million for the assumed HAI corporate debt and about $84.1 million for the assumed hospital debt. Thus, the total discount amounted to about $35 million. This amount, when added to the $93.9 million in

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[1]HCA assigned a portion of the allocated debt to "purchased goodwill" and as a result did not allocate about $22 million in interest for Medicare cost reporting purposes. For depreciable assets acquired after July 31, 1970, Medicare does not recognize the costs related to purchased goodwill. Purchased goodwill is the difference between the total purchase price and the value of the acquired assets based on the lower of fair market value or reproduction costs less accumulated depreciation.

[2]See page 25 for a discussion of this discounting as it relates to Medicare reimbursement.

[3]Some of the $103 million in hospital debt recorded by HCA as assumed debt was not really debt but rather capitalized leases on land and buildings. See page 31 for a discussion of this issue as it relates to Medicare reimbursement.

retired debt, approximately represents the $130 million difference between the debt at acquisition and the $595 million in debt HCA allocated to the assets.

The $425 million HCA borrowed at the time of the acquisition was obtained under a revolving credit agreement involving a number of banks. Several times during the period from August 27, 1981, through August 31, 1982, notes pertaining to the credit agreement matured and new notes were obtained. As of June 1982, $315 million was outstanding under the credit agreement, and HCA had borrowed about $100 million through debentures maturing in 2007 with a 15.625-percent interest rate. The interest rate on the notes obtained under the credit agreement ranged from 20.5 percent at the time of the acquisition to 11.69 percent in August 1982. We estimate that the annual interest cost incurred under the notes and the debentures during the first year after the acquisition was about $69 million.

The preexisting HCA corporate debt allocated to the assets acquired from HAI was $30 million in HCA 9.75-percent senior notes due in 1999.

INCREASED ANNUAL DEPRECIATION

Based on the appraisals it obtained, HCA more than doubled the value included in HAI's books for the acquired hospitals and medical office buildings and their related land, land improvements, and fixed equipment. The following table shows the increases in asset valuations.

Type of assets	Valuation		
	By HAI	By HCA	Increase
	(millions)		
Land	$ 22.2	$ 61.6	$ 39.4
Land improvements	2.9	6.9	4.0
Buildings	211.9	360.8	148.9
Fixed equipment	20.8	100.7	79.9
Total	$257.8	$530.0	$272.2

We estimated that depreciation expenses, using the straight-line method, will increase by over 80 percent, or about $8.4 million per year, as a result of increased asset valuations. Our

estimate of annual depreciation expense for the acquired hospitals and medical office buildings by type of fixed assets[4] before and after the acquisition is as follows:

Type of assets	Estimated annual depreciation expense HAI	HCA	Increase
	---------(millions)--------		
Land improvements	$ 0.2	$ 0.9	$0.7
Buildings	8.6	11.5	2.9
Fixed equipment	1.5	6.3	4.8
Total	$10.3	$18.7	$8.4

HCA did not appraise or revalue another depreciable asset--major movable equipment. Instead, HCA recorded this equipment at book value (historical cost less accumulated depreciation); therefore, depreciation expenses should not have increased for these assets. According to an HCA official, this policy was used because HCA believed any difference between appraised and book value would be insignificant. In March 1983, HCA informed the Blue Cross Association that the book value of major movable equipment at the time of the acquisition was about $52 million.

REDUCED HOME OFFICE COSTS

Home offices of chain organizations vary greatly in size, number of locations, staff, mode of operations, and the services furnished to providers in the chain. A home office usually furnishes management direction and control and such services as accounting and purchasing. The home office's costs are normally allocated to the hospitals.

Based on information contained in unaudited Medicare home office cost reports, HCA calculated an annual savings of about $27 million in home office costs. We reduced HCA's estimate to eliminate certain interest and one-time costs included in HAI's

[4]The value of the land acquired is not shown because land cannot be depreciated. The depreciation expense after the acquisition was computed based on the appraised values of the depreciable fixed real operating assets (land improvements, buildings, and building equipment). The appraisal of leased property is discussed beginning on page 26.

home office costs, which resulted in estimated home office savings of about $15.7 million as follows.[5]

		Home office costs
		(millions)
Annualized home office costs allocated by HAI		$38.0
Annualized home office costs allocated by HCA		11.0
Total decrease		27.0
Less annualized HAI home office interest expense already included in the $32.7 million in interest on page 8	$7.3	
Less HAI one-time costs (employee bonuses)	4.0	
Total GAO adjustments		11.3
Adjusted decrease in home office costs		$15.7

HCA officials said the savings resulted from an overall reduction in home office staffs--that is, HCA's home office staff after the acquisition was less than the sum of the preacquisition HCA and HAI staffs. Also, HCA's home office costs are now spread over more hospitals.

We did not review staffing levels to determine the number of HAI home office employees that left as a result of the merger or the number that HCA added to handle the additional workload. Nor did we review costs related to building rentals or service contracts to determine the number that were eliminated or added as a result of the merger.

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[5]We did not determine the exact amount of savings. HCA estimated the savings by subtracting the amount of home office costs it allocated to the 54 acquired hospitals from the amount allocated by HAI in the previous cost reporting period. We then adjusted this figure as indicated in the table. This methodology does not precisely measure changes in home office costs. However, because some of the hospitals acquired by HCA were later resold, because hospitals were acquired from other sources during the same period, and because of different organizational philosophies held by HAI and HCA, we could not precisely measure changes in home office costs after the acquisition.

HCA STATES THAT SAVINGS WILL ACCRUE FROM THE MERGER

A report HCA prepared for the Department of Justice before the acquisition stated that, as a result of the merger, some costs of operating the HAI hospitals could be reduced. HCA estimated that savings would result from, among other things, lower employee salary expenses, lower cost of supplies due to volume purchasing, savings in interest cost due to lower interest rates available to HCA because of its better credit rating, and lower bad debt losses. The HCA report claiming potential savings provided few details on how such savings could be achieved, and we could not evaluate these claims.

An HCA official told us that while HCA expects such savings to be substantial, it was too early to quantify the effects of the management improvements. He also said that, because some HAI hospitals have already been sold and the others have been incorporated into the overall data base with other HCA hospitals, quantifying such savings in the future would be extremely difficult.

EFFECT OF ACQUISITION ON COSTS AT TWO HOSPITALS

We did not determine the effects on costs at every hospital because of the number involved. Instead, we used as examples two hospitals that had filed Medicare cost reports after the acquisition. An HCA official suggested that we use these two hospitals. We later learned that these hospitals were leased, and after we completed our audit work, HCA sold its lease rights to the two hospitals to another corporation.

We used Medicare principles to allocate the changes in depreciation, interest, and home office expenses in the cost reports. We computed the increase in cost for the year after the acquisition on an overall, Medicare, and Medicaid basis for these three cost categories.[6] The increases are shown in the following table.

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[6]In developing these estimates, we adjusted the available data to reflect annual costs. Because the hospitals' pre- and post-acquisition cost reports were both for periods of less than 1 year, we divided the cost by the number of days in the reporting period to obtain the average daily cost and multiplied this by 365 days to obtain an annual cost.

	Lewisburg Community Hospital Lewisburg, Tennessee[a]		Sequatchie General Hospital Dunlap, Tennessee[a]	
	Increase in costs	Increase in cost per patient day	Increase in costs	Increase in cost per patient day
Overall	$1,030,767	$38.55	$296,635	$35.96
Medicare	426,118	26.35	94,269	21.34
Medicaid	38,655	30.51	23,015	27.30

[a]The only costs considered were depreciation, interest, and home office.

The increases in Medicare and Medicaid costs per patient day were less than the overall average increase at each hospital. One reason is that interest related to goodwill is unallowable and HCA deleted the amount of goodwill it calculated from the allocation of the costs in claiming Medicare and Medicaid reimbursement. One reason why the increase in cost per patient day was greater for Medicaid than for Medicare was because Medicaid patients' average length of stay is shorter than that of Medicare patients and therefore ancillary service costs were averaged over fewer days under Medicaid.

General information on these two hospitals and estimated interest, depreciation, and home office expenses are shown in appendixes I and II. We did not adjust the reported costs for the two hospitals to reflect the issues discussed in chapter 3 of this report.

In addition to our analysis of depreciation, interest, and home office expenses shown above, we computed the overall Medicare cost per patient day from Medicare cost reports before and after the acquisition. The change in overall costs reflects both increases in capital costs resulting from the acquisition and increases in operating costs resulting from inflation, changes in operations, and changes in occupancy rates and service utilization.

Hospital/cost reporting period	Reported Medicare total costs[a]	Reported Medicare patient days	Reported Medicare cost per patient day
Lewisburg:			
Before--1/ 1/81 - 8/26/81	$1,785,856	10,252	$174.20
After --8/27/81 - 5/31/82	2,746,973	12,312	223.11
Sequatchie:			
Before--1/ 1/81 - 8/26/81	460,788	2,930	157.27
After --8/27/81 - 3/31/82	479,636	2,626	182.65

[a]Total cost reimbursable to provider for inpatient services as included on the hospital's unaudited cost report for the indicated period.

During the cost reporting periods after the acquisition, the cost per patient day at the two hospitals increased by about 28 and 16 percent, respectively.

In its comments on the draft report, HCA said we failed to disclose that operating costs increased at a much lower rate than the national average. HCA said that operating costs (after capital costs are deducted) increased only $23 per patient day (or 13 percent) at Lewisburg and $4 per patient day (or 3 percent) at Sequatchie, while hospital increases nationally exceeded 17 percent. HCA attributed this to a number of operating benefits like those mentioned on page 13.

Our analysis of the cost reports for the periods before and after the acquisition showed increases in operating costs per patient day of 12.7 percent at Lewisburg (very close to the increase cited by HCA) and of 10.2 percent at Sequatchie (much higher than the increase cited by HCA). However, many factors can affect costs per patient day, such as operating efficiencies, changes in the average length of stay, changes in occupancy rates, and changes in the usage of ancillary services. Changes in these and other variables affect the cost per case. The increase in average operating costs per discharge was 16.6 percent for Lewisburg and 15.2 percent for Sequatchie.

RAPIDLY INCREASING VALUES ASSOCIATED WITH MULTIPLE SALES

While reviewing cost reports of hospitals involved in the merger, we noticed that some had changed ownership two or more times in recent years.[7] And, as the hospitals changed ownership, most asset valuations went up.

Red River Hospital, Wichita Falls, Texas, a small psychiatric hospital, is an example of such changes in ownership and subsequent changes in valuation. The hospital was built in 1971, and we do not know whether it changed ownership before 1977. However, in 1977 and twice in 1981, it changed ownership. The changing valuations of the assets are shown below.

	Cost reporting period		
Assets	Ending 3/23/81	3/24/81 to 8/26/81	Beginning 8/27/81
Land	$103,500	$ 258,393	$ 195,606
Land improvements	-	-	24,152
Building	670,966	1,649,748	2,425,110
Equipment	42,311	97,206	491,931
Total	$816,777	$2,005,347	$3,136,799

These increases in asset valuation have a direct relationship to interest and depreciation expenses charged to Medicare. Recently, limits on payment increase per discharge and a prospective reimbursement system have been legislated for Medicare. However, these changes do not apply to capital-related costs, such as interest and depreciation, because they are paid on a reasonable cost basis (see p. 2).

SUMMARY

Interest costs allocated to the hospitals and medical office buildings acquired by HCA from HAI increased by about $62.5 million for the first year after acquisition. Depreciation expenses for these assets, based on the straight-line method, increased by about $8.4 million per year. Somewhat offsetting these increased cost items were estimated decreased home office costs during the first year after acquisition (about $15.7 million lower) allocated to the acquired hospitals. As a result, the overall first year increase was about $55 million.

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[7]According to an HCA official, as of January 1983, HCA had sold its interest in 12 of the 54 hospitals acquired from HAI.

The increase in costs will be reflected in

--increased revenues through higher payments by hospital payors and/or

--decreased corporate earnings by HCA by absorbing the increased costs.

HCA COMMENTS

In commenting on this chapter, HCA said that, while capital costs have increased as a result of the acquisition, it believes there are a large number of operating benefits not mentioned in the report. As we pointed out on page 13, HCA reported to the Department of Justice that it expected that some operating costs of the former HAI hospitals could be reduced and it estimated savings in certain areas. However, as we also pointed out, the HCA report did not contain enough detail for us to evaluate it, and an HCA official told us that it was too early at the time of our fieldwork to quantify savings from the improvements instituted by HCA and that quantifying them in the future would be extremely difficult.

In addition, under Medicare's new prospective payment system for hospitals (see pp. 2 and 3), unless such operating savings were realized in the HCA hospitals' base year (cost reporting periods ended during fiscal year 1982), they will be retained by the hospitals, whereas capital cost increases will continue to be passed through to Medicare.

HCA also suggested that this chapter be clarified to point out that the $62.5 million is increased interest, and therefore the estimated $55 million in net increased costs included interest on the debt allocated to purchased goodwill for which HCA claimed no Medicare reimbursement. The $55 million refers to overall cost increases, not just those allowable under Medicare. To avoid any possible misunderstanding on this matter, we have clarified the report accordingly.

HCA's comments on this chapter, and our analysis of them, are presented in their entirety on pages 59 to 63.

CHAPTER 3

HCA'S HANDLING OF COST ITEMS ALLOCATED TO MEDICARE AND MEDICAID WOULD INCREASE PROGRAM COSTS

This chapter discusses how HCA allocated capital costs to Medicare. HCA used several methods that, in our opinion, are not in accordance with Medicare principles. HCA generally based its position on its interpretation of Medicare policy and on Generally Accepted Accounting Principles, which are designed to provide rules for reporting an entity's financial position, results of operations, and changes in financial position for present and potential investors and creditors. Although GAAP normally represents the appropriate principles for business financial statement purposes, it is not always appropriate for a cost reimbursement system such as Medicare's. Under Medicare, GAAP can be used only in those instances when Medicare's principles of reimbursement do not cover a situation.

Use of HCA's methods tends to increase Medicare payments and also Medicaid payments because the states normally use Medicare principles for their Medicaid programs. Specifically, the methods we question involved

- --allocating debt and related interest using a method different from the one Medicare prescribes;
- --discounting the debt HCA assumed from HAI, which had the effect of increasing the amount of interest claimed without demonstrably incurring additional interest expense; and
- --assigning inaccurate values to assets because of inconsistent practices in the appraisal and valuation processes.

QUESTIONABLE DEBT AND RELATED INTEREST ALLOCATIONS BY HCA

HCA allocated debt to the assets acquired from HAI based solely on the appraised value of the fixed real operating assets[1] of hospitals and medical office buildings. HCA did not consider the value of any of the other assets it acquired. However, Medicare's Provider Reimbursement Manual, section 203, establishes a different method for determining the amount of debt

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[1]As used by HCA, fixed real operating assets include land, land improvements, buildings, and building services equipment.

incurred in an acquisition for which interest expense can be allocated to the Medicare program. Use of the section 203 method would substantially reduce the amount of interest payable by Medicare.

A correct allocation of debt depends on an accurate determination of the value of the assets acquired. As we point out beginning on page 26, HCA's asset valuation was inaccurate. However, to illustrate the separate impact of HCA's debt allocation method, we have used HCA's asset valuations.

HCA's allocation method

HCA allocated the debt, and therefore the interest, related to the acquisition in the following manner, which we believe is inconsistent with Medicare requirements. HCA obtained appraisals of the value of the fixed real operating assets of the hospitals and medical office buildings acquired from HAI. These appraisals totaled $530 million. HCA then allocated $595 million in debt (the combined total of assumed and new debt) to the hospitals and medical office buildings based on these appraised values; that is, if the appraised value of the fixed real operating assets of a hospital represented 5 percent of the total appraised value, that hospital was allocated 5 percent of the total debt. Then HCA allocated the $140 million it had recorded (as of December 31, 1981) as goodwill to the hospitals and medical office buildings also based on the percentage of total appraised value represented by each facility. Interest on the debt related to goodwill as determined by HCA was deducted from the total allocated interest, and the remaining interest was included in the Medicare cost reports.

Thus, HCA allocated $595 million of debt, of which $140 million was assigned to goodwill. The cost reports for the period beginning August 27, 1981, reflect this allocation. However, in March 1983, HCA submitted to its home office intermediary a statement that the purchase price of the HAI assets was $930 million and that $180.9 million of this amount represented goodwill. The $40.9 million increase in the amount of goodwill above that used in preparing the Medicare cost reports will probably necessitate changing the cost allocations used in the cost reports; thus, the cost reports will probably need to be revised.

Allocation by the Provider Reimbursement Manual method

Although the Provider Reimbursement Manual does not specifically state how to allocate debt in a multihospital acquisition, section 203 sets forth a method for determining the amount of

debt that can be allocated for Medicare purposes to assets acquired when the purchase price exceeds the book value of the assets. In our opinion, because the section 203 method applies to the purchase of a single hospital, it also applies to the purchase of many hospitals. Section 203 requires that the allowable cost of the assets related to patient care be subtracted from the purchase price. The resulting amount (the excess of purchase price over allowable cost for Medicare purposes) is a combination of goodwill and the value of assets not related to patient care. This amount is not recognizable for Medicare purposes.

To determine the amount of debt that can be allocated for Medicare purposes, section 203 requires that the owner's investment be subtracted from the allowable cost of the assets related to patient care. The resulting amount represents the maximum amount of debt that can be allocated to the acquired assets for Medicare purposes.

The first step in the section 203 method is determining the purchase price. In a March 29, 1983, letter, HCA stated to its home office intermediary that the purchase price was $930 million. We computed a purchase price of $895.3 million by excluding the $34.7 million received by HCA for the nursing homes sold to Beverly Enterprises in 1981.

The second step is determining the value of the assets acquired that relate to patient care. Because HCA did not follow the section 203 method, we had to estimate an amount based on the appraised values provided by HCA. We began by totaling the appraised values of the hospitals' fixed operating assets[2] and the book value of their movable equipment, current assets, and other assets.[3] These values were also taken from the March 29 HCA statement to its home office intermediary.

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[2]We did not include the appraised value of the medical office buildings ($17 million) because normally the value of such buildings is not related to providing inpatient hospital care and thus is not includable in Medicare cost reports.

[3]We did not determine whether all of these assets were related to patient care. Costs associated with assets unrelated to inpatient care are not allowable under Medicare.

Appraised value of hospitals	$512,614,000
Book value of major movable equipment	52,127,000
Book value of current assets	78,961,000
Other assets	28,585,100
Total value of acquired assets related to patient care	$672,287,100

During our work we learned that the appraised value provided by HCA included the values of 14 leased hospitals. While these leases may have some value as intangible assets,[4] the value of the hospitals' assets should not be assigned to HCA because it does not own the hospitals. Therefore, we subtracted the appraised value of the leased hospitals ($191.3 million) from the total value of acquired assets related to patient care shown above, resulting in a revised value for these assets of $481 million. (See p. 31 for a more complete discussion of the leased assets.)

The third step under section 203 is to subtract the allowable cost of the acquired assets related to patient care ($481 million) from the purchase price ($895.3 million). This computation results in a total of $414.3 million in goodwill and assets not related to patient care which should not be used in computing debt allocation for Medicare purposes. HCA stated in the March 29 letter to the intermediary that the amount of goodwill in the HAI acquisition was $180.9 million.[5]

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[4]We did not attempt to assign a value to any intangibles that may have arisen. The value would be related to the specific terms of each lease, and certain terms would decrease the intangible value associated with a lease. For example, if a lease included an escalation clause for rent payments which resulted in full indexation of rent, the lease would have little, if any, intangible value. Leases under which the owner receives a percentage of the revenue generated by the hospital would also have less intangible value.

[5]Under HCA's allocation method, which did not address the value of the stock involved in the acquisition ($190 million), the total consideration given by HCA not allocated to hospitals was about $371 million; that is the total of goodwill and stock value.

The next step in the section 203 method is subtracting the amount invested by HCA[6] ($190 million in stock) from the allowable cost of the acquired assets related to patient care ($481 million). This subtraction results in the amount of debt that can be allocated to the acquired hospitals for Medicare purposes--$291 million rather than the $440 million allocated by HCA.

Medicare guidance is silent on how to allocate assumed versus new debt to allowable debt, but we believe it makes sense to allocate assumed debt first because it represents a preexisting liability. HCA assumed $84 million in debt directly attributable to individual hospitals and $56 million attributable to HAI's home office.[7] Assuming that all this debt is related to patient care, allocating it to the allowable debt for Medicare purposes would result in $151 million in new debt being allowable for Medicare purposes rather than the $300 million allocated by HCA. Because of the lower amount of applicable debt, the section 203 method would allocate about $22.3 million less in interest expense during the first year to the acquired hospitals than would HCA's method.

In commenting on the draft report, HCA said that it believed no savings would accrue to Medicare if section 203 were applied because of offsetting increases in return on equity payments from Medicare. The Blue Cross Association also said in its comments that considering return on equity payments would minimize or offset any savings related to applying section 203.

We agree that considering return on equity will affect the amount of Medicare payments to HCA. In fact, as we stated in footnote 6, return on equity was considered under the section 203 method which we used. Conversely, return on equity was not considered by HCA under the method it used in calculating allocable debt for Medicare. We do not agree, however, with HCA's and the Blue Cross Association's assertion that considering return on equity would offset the savings to Medicare that we believe will result under the section 203 method. To illustrate our point, we made the following calculations which show that first year costs allocable under Medicare computed as of the date of acquisition would be reduced by more than $6 million under the section 203 method.

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[6]In effect, this step substitutes a Medicare payment for return on equity capital (see p. 1) for a Medicare payment for interest expense. The difference in the amount of payment depends among other things on the difference between the rate of interest on the debt and Medicare's rate of return on equity capital.

[7]These are the discounted values of the assumed debt. See page 25 for a discussion of the allowability of discounting.

Equity for Medicare purposes is basically the difference between assets and liabilities. Because of the many changes after the date of acquisition (resale of hospitals, retiring some assumed debt, etc.) we have estimated, as shown below, on an annual basis, the difference in total allocable interest and return on equity between the section 203 method and HCA's method of allocating debt, as of the date of acquisition.

Section 203 Method of Computing Allocable Interest and Return on Equity

Net increase in equity	$190 million
Times the Medicare rate of return on equity for the period Sept. 1981-Aug. 1982	20.625 percent
Total allocable return on equity	$39.2 million
Total new debt allocable (see p. 70 for this computation)	$20.9 million
Times average rate of interest paid	16.3 percent
Total allocable interest	$ 3.4 million
Total allocable return on equity and interest	$42.6 million

HCA's Method of Allocating Debt

Total new debt allocable (see p. 22)	$ 300 million
Times average rate of interest paid by HCA	16.3 percent
Total allocable interest	$48.9 million

In summary, we estimate that the section 203 method which we used would have resulted in total allocable interest and return on equity during the first year after acquisition of $42.6 million. HCA's method of allocating debt resulted in $48.6 million in allocable interest. Thus, considering return on equity under the section 203 method would result in a reduction of first year costs allocable for Medicare purposes of about $6.3 million. (See pp. 69 to 71 for a more detailed discussion of our calculations.)

Other problems with HCA's debt allocation method

The above computations illustrate the proper method of debt allocation for Medicare and show that HCA's method substantially overstated allocable debt. However, further adjustments are necessary. For example, we did not determine the full extent of leased assets or assets unrelated to patient care. We were able to identify leased assets (primarily equipment) at six hospitals in addition to the 14 leased hospitals noted on page 21. The additional debt assigned to the leased assets at these six hospitals was valued at $1.3 million.

In addition to the medical office buildings noted on page 20, we identified the following examples of assets that appear to be unrelated to patient care:

--The appraisal report for Emerson A. North Hospital in Cincinnati listed 13 buildings and residences. Included were two vacant houses and a vacant nurses cottage with about 30 rooms. The depreciated reproduction costs of these three buildings were about $514,000. This appraised value does not include the market value of the land on which the buildings stand, which should also be considered.

--In another appraisal, an abandoned hospital (Hillsboro) was valued at about $247,000.

HCA comments on the applicability of section 203

HCA commented that, although it agreed that the section 203 method was required at the individual provider level, it believed this method was not applicable to a multihospital acquisition at the aggregate level. HCA said that it would be administratively impracticable for its home office intermediary to apply section 203 to the acquisition and that section 203 should be used at each hospital by its intermediary. In our opinion, it is a matter of conjecture whether it would be administratively easier for the home office intermediary to apply section 203 once or for the hospital intermediaries to apply it 54 times.

Although section 203 is phrased in terms of how to handle allocation of debt and equity at an individual acquired facility, it is the section dealing with this matter and it is evident to us that it should be used for a multihospital acquisition. Under Medicare, the provider is responsible for accurately reporting its costs in accordance with Medicare principles. The individual

acquired hospitals did not use section 203 to fill out their cost reports but merely included the allocations prepared by HCA. Also, because HCA did not allocate its investment to the hospitals, the hospitals could not do a section 203 allocation.

HCA comments and our analysis of them are presented in full on pages 64 to 74.

DEBT ASSUMED FROM HAI WAS DISCOUNTED

After the merger, HCA computed a discount on much of the debt it assumed from HAI that bore interest rates below the then market rate of interest. GAAP defines a discount as the difference between the fixed rate on the debt assumed and the effective yield rate for comparable securities at the time of the acquisition. It is the difference between the liability's present value and the amount that will eventually be paid. The effective yield rate used in computing the discount was 16.5 percent.

The discount related to the HAI corporate debt amounted to about $15.9 million. Overall, the discount on the assumed hospital debt was about $19 million, but because so many hospitals were involved in the merger, we did not review in detail the discount at each hospital. However, we obtained information from the acquisition workpapers prepared by HCA for 12 hospitals. An unamortized debt discount of about $9.3 million was recorded for 8 of the 12 hospitals. About $7.5 million of the $9.3 million was debt discount related to capitalized leases.

The discount is recorded in an unamortized discount account, and in each accounting period a portion of the discount is expensed as interest. Thus, discounting results in reporting to Medicare an imputed cost as a reimbursable interest expense. An HCA official said HCA recorded the discount because, if it had to pay off the old loans and borrow the money, the interest would be at the current rate.

While GAAP[8] states that for business combinations accounted for by the purchase method, the discount should be recorded, Medicare law allows only costs actually incurred to be paid by Medicare. This discounted interest was not shown to be an incurred cost.

Furthermore, a HCFA official said that although the Medicare regulations were silent on debt discount, 42 C.F.R. 405.419(b) defines interest as the cost incurred for the use of borrowed

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[8]See page 3 for a discussion of the relationship between GAAP and Medicare principles of cost reimbursement.

funds. As a result, Medicare would reimburse the interest paid the lender, but not the discount, which is an imputed cost.

A discount was computed not only on long-term debt but also on leases that had been capitalized by HAI; that is, leases that HAI had recorded in its books as long-term debt. For example, HAI treated the Medical Center Del Oro as a capitalized lease and accounted for the hospital by recording $8,128,000 in capitalized leases as long-term debt and $151,000 in notes payable as long-term debt. HCA also capitalized the lease and recorded the same amounts. However, HCA also discounted the amount of capitalized leases shown as long-term debt and recorded an unamortized discount of about $2.0 million. The discount on the $151,000 in long-term debt was about $23,000.

For the three leased hospitals where we obtained sufficient information to evaluate the discount on capitalized leases recorded as long-term debt, the discount totaled $7.5 million.

HCA comments on debt discounting

In its comments HCA maintained that discounting the assumed debt was allowable for Medicare purposes. HCA cited two cases that it said were similar to its situation in which Medicare's Provider Reimbursement Review Board[9] allowed interest claims exceeding the stated debt interest rates. However, neither case was similar. Both involved seller financing at favorable interest rates with documented evidence of the consideration paid for the favorable financing. We believe these cases support our position that the provider must demonstrate that discount interest was actually incurred before it is allowable. In our opinion, HCA has not demonstrated this.

HCA's complete comments on this issue and our analysis of them are presented on pages 75 to 77.

ASSET APPRAISALS AND VALUATIONS USED INCONSISTENT METHODS

The values assigned to the real assets acquired by HCA may not be accurate because of inconsistencies between the appraisal and valuation processes. Specifically,

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[9]The Provider Reimbursement Review Board was established under the Medicare law (42 U.S.C. 1395(oo)) to review disputes involving more than $10,000 between providers and intermediaries about the application of Medicare principles.

--different useful lives were used in appraising and depreciating the acquired assets;

--in computing depreciation, acquired assets were assumed to have no salvage value; and

--values were assigned to leased assets which resulted in higher interest and depreciation expenses being claimed.

In addition, the independence and accuracy of the appraisals are questionable because the appraised values were changed at HCA's request.

Assigning an accurate value to the assets included in the HCA acquisition of HAI is important for several reasons. For example, depreciation on buildings and equipment is normally an allowable expense for Medicare and Medicaid. Also, the debt related to the merger on which interest is allowable for Medicare cost reporting purposes is based on the value of the acquired assets related to patient care.

HCA hired an appraisal company to determine the value of real property acquired from HAI. The appraisal reports showed the company's estimates of fair market value of the land and depreciated reproduction cost[10] for buildings, building services equipment,[11] and land improvements.[12]

The appraised value of building service equipment was changed

We question the independence of the appraisals and their accuracy because at HCA's request the appraiser changed the value assigned to building services equipment after completing the initial appraisals. These values were altered so that they represented about one-half of those shown in the earlier reports. The amount that was subtracted from the building services equipment account was added to the value shown for the building account so

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[10]The costs to reproduce a duplicate facility considering the construction time factor and using the same design and materials, less a deduction for accrued depreciation.

[11]Equipment that is attached to the building structure and used in the building's basic operations, such as heating, air-conditioning, and electrical systems; plumbing; and elevators.

[12]Features--such as roads, parking lots, fences, outside lighting, and storm sewers--added to the land to increase its usefulness for particular purposes.

that the total estimated value for each hospital remained the same. The total amount shifted between these asset classes was about $100 million. This revision of appraised values would have the effect of increasing valuations for depreciation and debt allocation purposes by $28.2 million above those that would have been calculated using Medicare-approved useful life estimates on the original appraised value.

In its comments HCA said that it requested the appraiser to reallocate half of the appraisal value of building services equipment to buildings because the original allocations were inconsistent with HCA's accounting practices. HCA said its practice is to allocate the labor and material portion (about 50 percent) of such items as conduit, standpipes, and ductwork to the building because such items are not usually replaced during the building's life. Our position is that if HCA wanted to reallocate, it should have done so itself and justified its reallocation. We believe it is the appraiser's responsibility to independently and impartially appraise the value of the assets. This position is supported by "The Principles of Appraisal Practice and Code of Ethics" of the American Society of Appraisers. (See pp. 77 to 81 for HCA's complete comments on this issue and our analysis of them.)

Impact of useful life estimates

The value representing depreciated reproduction costs depends greatly on the assets' estimated useful life. Medicare regulations state that the estimated useful life of a depreciable asset is its normal operating or service life. Factors to be considered in determining useful life include normal wear and tear, obsolescence due to normal economic and technological changes, climate and other local conditions, and the provider's policy for repairs and replacement. In selecting a proper useful life for computing depreciation under the Medicare program, providers may use the useful life guidelines published in the American Hospital Association's (AHA's) 1973 edition of Chart of Accounts for Hospitals.[13] A different useful life may be approved by the intermediary if the provider's request is properly supported by acceptable factors that affect the useful life determination.

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[13]Recently, section 104.17 of the Provider Reimbursement Manual was revised to indicate that for assets acquired after December 31, 1981, providers may use AHA's 1978 Edition of Estimated Useful Lives of Depreciable Hospital Assets. However, for assets acquired in 1981 or earlier, providers cannot use the 1978 Edition. Providers may also use the useful life guidelines published by the Internal Revenue Service for assets acquired before January 1, 1981.

Both the 1973 and 1978 editions of the AHA guidelines show a maximum useful life of 40 years for buildings. Fixed assets in the buildings (such as elevators, heating, air-conditioning, plumbing, and electrical systems) are part of building services equipment, most of which has a suggested useful life of between 10 and 20 years. Land improvements, such as parking lots, also generally have a suggested useful life of 10 to 20 years.

In calculating depreciation, HCA basically used estimated useful lives of 40 years for buildings and 20 years for building services equipment. However, in calculating depreciated reproduction costs, the appraisal reports we reviewed for HAI assets acquired by HCA used an economic life of 50 years for both hospital buildings and building services equipment. Using a 50-year life substantially increased depreciated reproduction costs compared with those that would have been computed using the AHA useful life guidelines. For example, one small psychiatric hospital had a total estimated reproduction cost of $3,646,301. Because the building was 10 years old at the time of the merger, 20 percent (10 years divided by 50 years) was subtracted from the total estimated reproduction cost to arrive at the depreciated reproduction cost of $2,917,041. If the AHA useful life guidelines had been applied by the appraiser to determine reproduction values, the depreciated reproduction cost would have been about 11.5 percent lower. Assuming a 40-year building life and a 20-year building services equipment life, estimated reproduction costs would have been reduced by 25 percent (10 years divided by 40 years) for the building and 50 percent (10 years divided by 20 years) for the building services equipment, rather than the 20 percent that was used for both. Using these useful life estimates, the depreciated reproduction cost would have been $2,580,997, or $336,044 (11.5 percent) less than that shown on the appraisal.

The depreciated reproduction cost based on a 50-year useful life was used as the basis for debt allocation, and therefore for interest expense and for depreciation expense. Thus, a reduction in the depreciated reproduction cost based on AHA useful life estimates (generally 40 years for buildings and 20 for equipment) would result in considerable reductions in depreciation and interest expenses charged to Medicare. Depreciation would be lower for the same depreciation period because each hospital would have a lower basis upon which to compute depreciation. Interest expense would be lower because the total value of the acquired assets related to patient care would decrease.

In its comments HCA stated that although consistent application of useful lives could result in different depreciated reproduction costs, this is irrelevant because the appraiser is entitled to use the useful life guidelines it chooses. HCA went on

to say that the appraiser's selection of useful lives for determining values has no application to HCA's written depreciation policies.[14]

In our opinion the useful lives used by the appraiser are relevant to Medicare because depreciated reproduction costs result from the appraisal process and these values are highly dependent on the useful life used. The appraiser's application of a 50-year useful life resulted in the total depreciated reproduction cost being $77.3 million higher than it would have been applying AHA's useful life estimates, which HCA used to compute depreciation. This resulted not only in higher depreciation claims but also in higher allocation of debt and thus interest. HCA's complete comments on this matter and our evaluation of them are presented on pages 81 to 84.

Salvage value

Medicare guidelines state that salvage value, if any, should be considered in computing straight-line depreciation. In determining the basis for straight-line depreciation, HCA did not deduct anything for salvage value. Salvage value is the estimated amount expected to be realized upon the sale or other disposition of the depreciable asset when it is no longer useful to the provider. Medicare's Provider Reimbursement Manual states that the amount is ordinarily estimated at the time of acquisition and is deducted from the cost of the depreciable property to arrive at the basis for depreciation.

Our review of a limited number of appraisals and two hospital depreciation computations shows that salvage value was not stated in the appraisal reports or considered in the depreciation computations. HCA in its comments said it considered salvage value but did not compute it. HCA said that the hospital industry does not as a practice assign salvage values to depreciable assets and depreciation is almost always computed without regard to this component. (See pp. 84 and 85.) In our opinion, Medicare clearly requires that salvage values be considered, and we believe HCFA should assess compliance with this requirement.

We believe that such assets as office equipment and buildings would have some salvage value. For example, one hospital building acquired in the merger is now used as a laboratory.

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[14]Although arguing here that the appraiser should not be concerned with its clients' policies, HCA argued earlier that it was proper for the appraiser to reallocate appraised values in order to meet HCA's policy.

Depreciation expense would decrease if salvage value were deducted from the asset valuation. For example, at one hospital (Encino Hospital, Encino, California) with assets valued at $22.1 million, the depreciation expense would be $91,849 less per year if a 10-percent salvage value were used. The computations are shown in appendix III.

Leased assets incorrectly valued

Real assets at hospitals were appraised and revalued without regard to whether HCA purchased the assets or merely acquired the right to use them through leases. One of the qualifications stated in the appraisals was that the appraiser did not look into the assets' ownership. HCA identified 14 leased hospitals for the intermediary.

In documents furnished to us, the leases were classified as capitalized or operating leases and in some cases classified differently in different documents. While Medicare does not recognize capitalized leases for reimbursement purposes, GAAP uses a different accounting treatment for operating and capitalized leases. When a lease is capitalized, it is treated as a purchase, and the asset and related debt (present value of future lease payments) are recorded in the accounting records. Each accounting period, the asset is amortized, and the lease payment is recorded as interest expense and a reduction in debt. For an operating lease, the lease payment is recorded as a rental expense during the accounting period, and no accounting entries are made in the balance sheet accounts.

Although Medicare regulations do not recognize capitalized leases for reimbursement purposes, they give criteria for classifying a lease as a virtual purchase[15] under a lease/purchase agreement. If the lease is classified as a virtual purchase, the

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[15]The existence of the following conditions will generally establish a lease as a virtual purchase:

--The rental charge exceeds rental charges of comparable facilities or equipment in the area.

--The term of the lease is less than the useful life of the facilities or equipment.

--The provider has the option to renew the lease at a significantly reduced rental or the right to purchase the facilities or equipment at a price that appears to be significantly less than what the fair market value would be at the time acquisition by the provider is permitted.

maximum amount that can be included in the Medicare cost report is the lower of (1) the rental payment[16] or (2) the amount that the provider would have included in allowable costs if it had legal title to the assets; that is, straight-line depreciation, insurance, interest, etc.

The 14 leased hospitals represent a substantial portion of the value assigned to the assets involved in the HCA acquisition of HAI. Of the $530 million that HCA shows as the value of real operating assets acquired from HAI, about $191 million (or about 36 percent) represents the value assigned to these 14 hospitals. As shown below, the value HCA assigned to these hospitals more than doubled over that recorded by HAI and the debt allocated to them more than quadrupled as a result of the merger.

Time period	Value assigned	Debt allocated
	(millions)	
Before merger	$ 77.1	$ 49.8
After merger	191.3	214.8[a]
Increase	114.2	165.0

[a]Part of this debt was allocated to goodwill by HCA.

Besides the leased hospitals, other hospitals had leased items, primarily equipment, that could affect the allocation of debt to the acquired hospital. We obtained sufficient information on six owned hospitals to determine the amount of capitalized leases recorded as assets as of August 26, 1981, the day before the merger. For these hospitals $1.3 million of the total $6.6 million in long-term debt recorded by HCA represented capitalized leases. The values of these leased assets should be subtracted from the value of assets related to patient care when the section 203 allocation is performed.

Impact of HCA's lease rights valuation

Many of the claimed expenses that are related to real assets are incorporated into the Medicare cost reports under the caption "Depreciation-Buildings and Fixtures." In addition to depreciation, other expenses--such as interest, rent expense, and property taxes--are included there. As an example of the impact the HCA acquisition has had on this "depreciation" category, we

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[16]If the lease calls for the lessee to pay taxes, insurance, utilities, or similar items, they can also be allowable costs for Medicare.

looked at cost reports for the three most recent reporting periods for Doctors Hospital in Little Rock, Arkansas, one of the hospitals HCA operates under a lease. The following table shows the total amount included in the cost reports for depreciation on buildings and fixtures and the average cost per inpatient day for each period.

	Cost reporting period		
	1/1/80 to 12/31/80	1/1/81 to 8/26/81	8/27/81 to 2/28/82
Total amount	$1,743,324	$1,394,989	$3,335,585
Average cost per inpatient day	$21.27	$25.42	$92.34

This table shows the substantial increase in claimed capital expenses. In less than a year, capital expenses per patient day for this leased hospital almost quadrupled.

The amount of the basic lease payment--$83,833 per month--remained constant over the three periods. If the amount attributable to the actual lease payments is deducted from the overall "depreciation" cost per patient day, the additional amount for the other factors, such as interest, depreciation, amortization, and taxes, was as follows:

	Cost reporting period		
	1/1/80 to 12/31/80	1/1/81 to 8/26/81	8/27/81 to 2/28/82
Average cost per inpatient day in addition to lease payment	$8.99	$13.45	$78.04

We believe that a clear distinction needs to be made between owned assets and those used under operating leases. We believe that the "asset" value of the leases acquired by HCA are substantially overstated and that the ownership-type costs related to these assets that were claimed in the cost reports should be adjusted to reflect the costs incurred under the leases to the extent such costs are reasonable.

HCA comments of lease valuation

In its comments HCA said that there is no question that acquired leases may be revalued to reflect their actual fair market value at the date of acquisition. HCA's rationale is that it acquired valuable rights through the leases and that the value of

the acquired lease rights is equal to the appraised value of the leased assets less the rental payments.

As we discussed in footnote 4, page 21, the acquired lease rights could have intangible value which could be used in allocating costs, but we believe any such value can only be determined by evaluating the terms of the leases. We believe that the value of the acquired lease rights is related to the difference between the actual payments under the lease and the amount of rent that would have been paid if the same facility were leased on the day of acquisition. We believe that this rental difference should be evaluated in light of the degree of protection the acquired leases provide against increases in rents. Our review of the leases showed that they contained relatively little protection against rental increases and, therefore, would not have the high intangible value assigned to them by HCA.

HCA's complete comments on this matter and our analysis of them are presented on pages 85 to 93.

REIMBURSEMENT FOR CERTAIN CLAIMED COSTS NOT FINALIZED

The responsible Medicare intermediaries have not finalized the amount of capital costs associated with the acquisition that they will recognize for Medicare purposes, and they may deny reimbursement for certain expenses claimed by HCA based on the facts in each case or the intermediaries' interpretation of HCFA's guidance. For example, we looked at cost reports and other data for Lewisburg and Sequatchie Hospitals (discussed on pp. 13 to 15) and Orthopaedic Hospital of Charlotte, Charlotte, North Carolina (discussed below). All three of these hospitals were leased. For the preacquisition cost reports that had been finalized, Medicare intermediaries allowed lease payments or depreciation and interest costs up to the rental payment limit depending on whether the lease was considered a virtual purchase.

For Orthopaedic Hospital of Charlotte (an operating lease which the provider capitalized), the following describes the capital expenses recorded and the intermediary audit adjustments to the cost reports.

--For the year ended December 31, 1980, the intermediary excluded the reported interest and depreciation expense of $576,380 and $165,912, respectively, and allowed the $448,000 annual lease payment. An intermediary official said the same type of adjustment was made in the cost report for the period January 1 through August 26, 1981. Both cost reports were audited at the same time.

--For the cost reporting period August 27, 1981, through February 28, 1982, the provider reported interest and depreciation expense of $410,726 and $56,069, respectively. The provider reduced interest expense by $260,409 because this amount was related to goodwill allocated to the provider and included the lease payments of $228,296. Thus, the provider claimed allowable costs of $417,610. The intermediary, in an uncompleted audit, told us it planned to exclude the reported interest and depreciation expense and allow only the actual lease payments.

In contrast, because the leases were considered virtual purchases, for the cost reporting period ended December 31, 1980, the intermediary responsible for Sequatchie and Lewisburg Hospitals allowed both depreciation and interest expenses up to a maximum of the amount of rental payments for these leased hospitals. An intermediary official said Sequatchie was also allowed depreciation and interest cost up to rental payments for the period ended August 26, 1981.

CONCLUSIONS

In allocating debt and related interest expenses as well as depreciation for the acquired HAI hospitals, HCA did not, in our opinion, follow Medicare guidance. As a result, HCA hospitals claimed excessive capital costs in their cost reports.

Medicare reimbursements for hospital services will be higher under HCA ownership because the $425 million borrowed to finance the transaction and the revaluing of assets have increased hospital interest and depreciation expenses. Intermediaries should be aware of the potential for claiming excessive costs in such transactions to prevent excessive payments from the Medicare trust fund. Because hospital capital costs will continue to be paid on a reasonable cost basis for at least 3 more years, because HCA misinterpreted Medicare guidelines, and because other hospital acquisitions are likely, we believe HCFA should clarify how Medicare guidelines apply to the situations discussed in this chapter.

Another reason to assure that guidelines on accounting for acquisitions are complete and clear is that, if an acceptable method for including capital costs in prospective payments is developed, it will be important to know what allowable costs were in the past and are in the future because prospective payment rates are normally based on costs.

RECOMMENDATIONS

We recommend that the Secretary of HHS direct the Administrator of HCFA to assure that the intermediaries consider our

findings when finalizing the amount of increased costs associated with this acquisition that will be recognized as allowable by Medicare.

The Secretary should also direct the Administrator to clarify Medicare guidelines as they relate to

--procedures for allocating debt and interest expenses for multiasset acquisitions;

--prohibiting the discounting of assumed debt; and

--acceptable asset valuation procedures when appraisals are used, including independence of the appraiser, consideration of the ownership of the assets, and useful life consistency.

HHS COMMENTS

In commenting on the draft report, HHS said that our findings will be considered in settling the cost reports affected by the acquisition. HHS also said that it had not finalized its position on the issues addressed in the report.

Regarding our recommendation to clarify Medicare guidelines, HHS said that it was reviewing its operational instructions in the areas we listed and would clarify them in light of our findings.

BLUE CROSS COMMENTS

The Blue Cross and Blue Shield Association said that it would continue to work with HCFA to resolve the issues related to the Medicare treatment of the costs associated with the acquisition, giving appropriate consideration to our findings. The Association also said that its research in many of the areas we raised was not as conclusive on the scope and clarity of Medicare policy as we suggested. While we believe that our conclusions regarding the application of Medicare reimbursement principles are correct, we agree with the Association that the principles' applicability could be clarified. That is why we are recommending that HHS clarify its guidelines relating to these areas.

HCA COMMENTS

HCA commented that it believes it has properly applied Medicare principles in handling the costs associated with the acquisition of HAI's assets. HCA presented its rationale for treating the costs as it did.

We believe that HCA misinterpreted Medicare principles and that this has resulted in its claiming more reimbursement from Medicare than is allowable. HCA's position regarding the issues discussed in the report are presented in the applicable sections of the report along with our analysis. HCA's complete comments and our analysis of them are included in appendix VI.

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Additionally, HCA supplemented its initial comments by letter dated November 18, 1983. In that letter, HCA requested that we include in the report information to the effect that as a result of the acquisition, INA had realized ordinary and capital taxable gains of $470 million and that the related federal and state income tax liability was about $160 million. We have not verified this information. Also, we do not see the relevance of corporate gains on the sale of assets to the issue of hospital capital costs under the Medicare and Medicaid programs.

DATA INCLUDED IN UNAUDITED COST REPORTS FOR

LEWISBURG COMMUNITY AND SEQUATCHIE GENERAL HOSPITALS

	Lewisburg Community cost reporting periods		Sequatchie General cost reporting periods	
	1/1/81-8/26/81	8/27/81-5/31/82	1/1/81-8/26/81	8/27/81-3/31/82
Number of beds	119	119	49	49
Number of days in reporting period	238	277	238	216
Total inpatient days available during reporting period	28,322	32,963	11,662	10,584
Total inpatient days	17,479	20,250	5,919	4,905
Percent occupancy	61.7	61.4	50.8	46.3
Medicare inpatient days	10,252	12,312	2,930	2,626
Medicaid inpatient days	858	949	720	435
Percent Medicare/ Medicaid days	63.6	65.5	61.7	62.4

APPENDIX I

LEWISBURG COMMUNITY AND SEQUATCHIE GENERAL HOSPITALS' ESTIMATED INTEREST, DEPRECIATION, AND HOME OFFICE EXPENSE BEFORE AND AFTER ACQUISITION BASED ON HCA DATA[a]

Lewisburg Community

Expense	Before acquisition	After acquisition	Increase or decrease (-)
Interest	$243,035	$1,171,294	$ 928,259
Depreciation	115,510	246,063	130,553
Home office	239,920	211,875	-28,045
Total	$598,465	$1,629,232	$1,030,767

Sequatchie General

Expense	Before acquisition	After acquisition	Increase or decrease (-)
Interest	$ 70,728	$365,424	$294,696
Depreciation	74,075	85,001	10,926
Home office	81,131	72,144	-8,987
Total	$225,934	$522,569	$296,635

[a]All values are annualized. The asset values upon which we based the computations for interest, depreciation, and home office expenses after the acquisition are those shown in the appraisals.

COMPUTATION OF SALVAGE VALUE AND ANNUAL SAVINGS IN DEPRECIATION EXPENSE USING AN ASSUMED SALVAGE VALUE OF 10 PERCENT[a]

	Depreciated reproduction cost	10-percent salvage value	Cost to be depreciated	Useful life
Building	$16,680,549	$1,668,055	$15,012,494	30
Fixed equipment	5,437,001	543,700	4,893,301	15
Total	$22,117,550			

	Based on depreciated reproduction cost	Based on depreciated reproduction cost less salvage value	Difference
Building	$556,018	$500,416	$55,602
Fixed equipment	362,467	326,220	36,247
Total	$918,485	$826,636	$91,849

[a]We based these computations on the asset values shown in the appraisal for Encino Hospital, Encino, California.

APPENDIX IV

DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

SEP - 6 1983

Mr. Richard L. Fogel
Director, Human Resources
Division
United States General
Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

The Secretary asked that I respond to your request for our comments on your draft of a proposed report "Hospital Merger May Cost Medicare and Medicaid Millions." The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

We appreciate the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Hospital Merger May Cost Medicare and Medicaid Millions"

Overview

At the request of Representative Willis D. Gradison, Jr., GAO has conducted this review to determine the impact on health care costs of the acquisition by the Hospital Corporation of America (HCA) of the assets of Hospital Affiliates International, Inc. from INA Corporation. The report focuses on changes in interest expense, depreciation, and corporate level management expenses (home office expense) because these are the costs, according to GAO, most likely to change significantly as the result of an acquisition.

GAO reports that during the first year after the acquisition (1982), the cost of the acquired hospitals increased by a net amount of about $55 million due to changes in interest, depreciation, and home office expenses. GAO went on to review the procedures used for Medicare cost reporting purposes by HCA to allocate interest to the acquired hospitals and the value for depreciation purposes of the assets acquired.

GAO basically concludes that HCA did not follow Medicare reimbursement principles in allocating debt and related interest expenses as well as depreciation for the acquired hospitals. The effect of such improper allocation has resulted in the claiming of excessive capital costs in HCA's cost reports. Accordingly, GAO believes intermediaries should be aware of the potential for claiming excessive costs in transactions of this type to prevent excessive payments from the Medicare trust fund. Additionally, GAO notes that because hospital capital costs will continue to be paid on a reasonable cost basis for at least 3 more years and because other hospital acquisitions are likely, GAO believes HCFA should clarify Medicare guidelines in this area.

GAO Recommendation

That the Secretary of HHS direct the Administrator of HCFA to assure that the intermediaries consider our findings when finalizing the amount of increased costs associated with this acquisition that will be recognized as allowable by Medicare.

Department Comment

The findings presented in the report will be considered in the settlement of the cost reports affected by the merger. It should be recognized, however, that we have not yet finalized our position on the issues addressed in the report.

GAO Recommendation

The Secretary should also direct the Administrator to clarify Medicare guidelines as they relate to:

-- procedures for allocating debt and interest expenses for multi-asset acquisitions;

APPENDIX IV

-- prohibiting discounting of assumed debt; and
-- acceptable asset valuation procedures when appraisals are used, including independence of the appraiser, consideration of the ownership of the assets, and useful life consistency.

Department Comment

We are in the process of reviewing our operational instructions in these areas and will take steps to clarify them where appropriate in light of the findings discussed in the report.

APPENDIX V

Blue Cross
and
Blue Shield
Association

Medicare

676 North St. Clair Street
Chicago, Illinois 60611
312/440-6000

August 30, 1983

Mr. Richard L. Fogel
Director
United States General Accounting Office
Washington, D.C. 20548

Dear Mr. Fogel:

Thank you for the opportunity to review the draft GAO report entitled "Hospital Merger May Cost Medicare and Medicaid Millions".

Together with Blue Cross and Blue Shield of Tennessee, the designated home office intermediary for the affected chain organizations, we have devoted considerable resources to the legal and reimbursement analyses of this transaction for the Medicare program. We have also maintained a close working liaison with the Health Care Financing Administration (HCFA) to ensure a proper and thorough review and resolution. Complex technical issues have been identified during our analyses, many of which have been featured in this draft report. Our research on these issues has been completed, and our preliminary report has been delivered to HCFA for a final determination. We will continue to work with HCFA for an early resolution of these issues, with appropriate consideration to the findings in the GAO report.

We have two comments with regard to the content of the draft report.

o The GAO inquiry had been limited in scope to the changes in interest expense, depreciation, and home office costs resulting from the change in ownership. In a proprietary setting, however, a proper perspective on the effects of a change in ownership cannot be achieved without consideration to the impact of the return on equity capital.

  Return on equity is a most material item in viewing this specific transaction and will minimize, if not offset, the cost effects which have been described in the draft report. The increased interest expense claimed is a result of the debt incurred. This

debt will decrease the equity of the providers. Any shifting of interest expense to nonallowable areas will also shift the corresponding debt, thus increasing the equity of the patient care related areas.

To illustrate the materiality of the return on equity, the rate of return for provider fiscal years beginning January 1, 1982 and ending December 31, 1982 is 20.000%, which exceeds the interest rate on the assigned debt.

The conclusions which will be drawn from this report should, therefore, be tempered by the fact that one major element -- the return on equity capital -- has not been addressed.

o Many of the issues discussed in the draft report focus on the use of Medicare reimbursement principles versus the use of generally accepted accounting principles (GAAP). Where the Medicare program has not addressed an issue, reference must be made to GAAP for proper accounting treatment.

The central question to be answered is whether Medicare currently has a policy which specifically addresses the issue and prescribes a treatment other than the one presented by the chain organizations using GAAP. Our research in many of the areas raised by GAO is not as conclusive on the scope and clarity of Medicare policy as is suggested in this draft report.

Our work with HCFA on this question is still in progress, and GAO's findings will be considered before a final reimbursement determination is made.

Thank you for the opportunity to comment on the draft report.

Sincerely,

Merritt Jacoby

Merritt W. Jacoby
Executive Director
Medicare A Administration

APPENDIX VI

Hospital Corporation of America
One Park Plaza, P.O. Box 550
Nashville, Tennessee 37202
Tel (615) 327-9551

Thomas F. Frist, Jr., M.D.
President and Chief Executive Officer

HCA Hospital Corporation of America

August 29, 1983

Mr. Richard L. Fogel
Director, Human Resources Division
United States General Accounting Office
Washington, D.C. 20548

Re: U. S. General Accounting Office
Draft Report "Hospital Merger May
Cost Medicare and Medicaid Millions"
Your Code No. 106232

Dear Mr. Fogel:

On August 1, 1983, you forwarded the referenced draft report to me for review and comments. The draft report addresses hospital cost increases arising from the purchase by Hospital Corporation of America (HCA) of Hospital Affiliates International, Inc. (HAI).

HCA strongly disagrees with the report's assertions of questionable or improper conduct attributed to it in connection with its Medicare claims arising from the acquisition. This disagreement is underscored by two basic facts. First, virtually all of the actions complained of have been reviewed and approved by HCA's fiscal intermediary and by Blue Cross Association. Second, HCA's conduct that is complained of as questionable is consistent with Medicare guidelines or administrative or court decisions.

We believe this draft report is replete with misconceptions regarding Medicare reimbursement. There are a number of problems with the report: it misstates Medicare policies and almost never refers its readers to any Medicare rules or guidelines to support its conclusions; it contains a large number of factual errors which must be corrected; and it repeatedly confuses Medicare costs with total costs and generally misleads its readers as to which costs are being discussed.

After you have reviewed our detailed comments on the draft report which are enclosed, we request you consider using a more objective and less sensational title, e.g.: "Effect of Hospital Mergers on Medicare and Medicaid Costs".

Because of the serious nature of our concerns we request a meeting with you and the appropriate HCA representatives during the week of September 12, if this time is convenient. I have asked Helen King Cummings, Vice President, Reimbursement, to call your office the week of September 5 to confirm with you the time and place for the meeting.

Very truly yours,

Thomas F. Frist, Jr., M.D.

Enclosure

TFF/nvs

GAO note: See the detailed HCA comments for our analysis of and response to the issues raised by HCA.

HOSPITAL CORPORATION OF AMERICA

Response to General Accounting Office Draft Report
"Hospital Merger May Cost Medicare and Medicaid Millions"

This Memorandum addresses the U.S. General Accounting Office draft report "Hospital Merger May Cost Medicare and Medicaid Millions" transmitted to Thomas F. Frist, Jr., M.D. on August 1, 1983. The draft report addresses hospital cost increases resulting from the acquisition by Hospital Corporation of America ("HCA") of Hospital Affiliates International, Inc. ("HAI").

Before addressing the draft report in detail, five overall factors should be considered:

(a) HCA's philosophy is to provide quality patient care at a competitive price in full compliance with all legal requirements. At the same time, HCA strives to maintain the highest degree of ethical standards. The merger between HCA and HAI, a subsidiary of INA Corporation, concluded between two publicly held corporations, was conducted in full compliance with the requirements of, and disclosures to, all appropriate federal and state agencies including the Department of Justice, Securities and Exchange Commission, Federal Trade Commission, Internal Revenue Service, Health Care Financing Administration and the appropriate state certification and licensure

agencies. HCA believes this statement must be made because the draft report contains a number of assertions that HCA has engaged in questionable or improper conduct with respect to its claims to Medicare reimbursement, assertions that HCA strongly takes exception to.

(b) The actions taken by HCA in its acquisition of HAI hospitals, as required by generally accepted accounting principles and HCA's independent auditors, were based upon the results of an independent appraisal firm whose appraisal has been used for financial and Medicare reporting purposes. Moreover, all of HCA's actions relating to the merger have previously received preliminary approvals by HCA's fiscal intermediary and Blue Cross Association. The statutory merger, which would result in a step-up in basis, was also approved by the Health Care Financing Administration ("HCFA"). The draft report's author, therefore, appears to HCA to have engaged in a considerable amount of "second guessing" with interpretations of what the rules should be from the draft report author's viewpoint rather than a specific review of the rules in existence at the date of the merger.

(c) Since its inception Medicare has always recognized that hospital costs include the cost of ownership of capital assets used to provide patient care. The draft report recognizes that Medicare regulations permit revaluation of assets used in patient care if there is a statutory merger accomplished in accordance with state law and Medicare reimbursement principles (at 7-8). Nevertheless, the general overriding criticism of the draft report is that the costs of health care, including the cost to the Medicare and Medicaid programs, are improperly increased as a result of HCA's acquisition of HAI. Because the program set the criteria for paying costs associated with an acquisition, HCA believes it is improper to implicitly criticize HCA for its compliance with program rules.

(d) HCA's review of the draft report reflects that it contains a number of errors, omissions and misconceptions relating to the Medicare program. Moreover, in several places throughout the draft report gratuitous comments and criticisms appear regarding HCA's claims for Medicare reimbursement with neither substantiation nor reference to any specific program rule or guideline. In some cases, the criticisms actually contradict long

established program policy. The errors and criticisms which HCA feels are inappropriate are addressed throughout the response.

(e) The draft report fails to address in any manner the underlying economic basis for the Medicare capital cost increases which arise as a result of hospital acquisitions. These increases are related to the present cost of the capital acquired to provide patient care, a cost which is directly based on actual replacement cost of facilities. Increases in replacement costs are not recognized by Medicare program payment policies on a continuing basis, but only when assets are initially placed into service or sold. In paying historical cost only for the use of depreciable assets, the program is, therefore, not paying the real cost of the replacement of those assets. HCA therefore believes there is a significant omission in the draft report in failing to address this fundamental issue.

In general, HCA comments on the draft report appear in the same order as the discussion in the report.

GAO note: See HCA's detailed comments for our analysis of and response to the issues it raised.

GAO note: The following is a word-for-word copy of HCA's detailed comments except that

--the page numbers have been changed to reflect the page numbers in this report and

--the name of the appraiser was deleted.

Our analysis follows their comments.

HCA COMMENT:

I. [Chapter 1]
INTRODUCTION

The report's description of the Medicare program is, in general, an accurate one. However, the description has a significant omission and an error, both of which should be corrected. Omitted from the program description is any discussion of, or reference to, a number of program policies, rulings and regulations which specifically address the manner in which costs of acquisition are treated by Medicare. To leave out a discussion of the extensive program rules in the areas commented upon results in an unbalanced picture of the costs analyzed in the report.

GAO ANALYSIS:

The detailed Medicare policies concerning the handling of acquisition costs were not included in the introductory chapter. However, the applicable policies were discussed in the relevant sections of chapter 3, where HCA's treatment of acquisition costs for Medicare reimbursement purposes is addressed.

HCA COMMENT:

The error referred to is the general, and unsupported, conclusion that generally accepted accounting principles ("GAAP"), as a rule, do not determine Medicare allowable costs. The report throughout (at iv, 3, 18) mischaracterizes the relationship between GAAP and Medicare principles of reimbursement and erroneously indicates that HCA followed the former instead of the

latter. GAO mistakenly assumes that GAAP and Medicare are mutually exclusive. In fact, Medicare principles are usually in accordance with GAAP. Most program rules are based on GAAP and program policy specifically requires costs be determined under generally accepted accounting practices. Further, it is long-standing Medicare policy to utilize GAAP whenever there is no specific Medicare guidelines on point. See Foreward to the Provider Reimbursement Manual ("HIM-15") and Provider Reimbursement Review Board ("PRRB") Dec. No. 79-D62, CCH Medicare and Medicaid Guide [1979-2 Transfer Binder], §30,156, affirmed, HCFA Administrator decision, CCH Medicare and Medicaid Guide [1980 Transfer Binder], §30,323.

GAO ANALYSIS:

As we stated, Medicare's regulations and policy manuals provide an extensive set of procedures for claiming cost reimbursement from the program. Some of these policies are the same as or similar to GAAP, while others are different. As we stated, providers can use GAAP per se only when Medicare's policy guidance is silent on a particular point; otherwise, Medicare policy must be used whether or not it is the same as GAAP. The foreward to HIM-15 cited by HCA supports our position. It states:

> "The procedures and methods set forth in this manual have been devised to accommodate program needs and the administrative needs of providers and their intermediaries and will assure that the reasonable cost regulations are uniformly applied nationally without regard to where covered services are furnished. * * * For any cost situation that is not covered by the manual's guidelines and policies, generally accepted accounting principles should be applied."

HCA COMMENT:

Medicare regulations at 42 CFR §405.406(a) specifically require that "standardized definitions, accounting, statistics, and reporting practices which are widely accepted in the hospital and related fields [be] followed." Similarly, court cases from various jurisdictions support the application of GAAP as a basis for determining allowable costs under Medicare. See, e.g., Pacific Coast Medical Enterprises v. Harris 633 F.2d 123, 132 (9th Cir. 1980); AMI-Chanco v. United States 576 F.2d 320,

324 (Ct. Cl. 1978); Doctors Hospital v. Califano, 459 F.Supp 201, 208 (D.D.C. 1978).

GAO ANALYSIS:

42 C.F.R. §405.406(a) does not require that standardized definitions, etc., be followed. It states that Medicare principles of cost reimbursement follow such standardized definitions, etc., to enable providers to make use of data usually available to them. None of the court decisions cited by HCA dealt with issues in which the court substituted GAAP for a valid Medicare requirement.

HCA COMMENT:

Moreover, several of the HIM-15 provisions relating to depreciation and appraisals, i.e., the very subjects addressed by the draft report, expressly incorporate GAAP. For example, HIM-15 §104.10 defines "historical costs" as including "costs that would be capitalized under generally accepted accounting principles". See also HIM-15 §134.4 (fixed assets included in appraised values).

GAO ANALYSIS:

Section 104.10 of HIM-15 provides that "generally" historical cost includes costs that would be capitalized under GAAP and continues by listing some limitations on the allowable amount of historical costs. The section also refers to section 134.3, which discusses limitation on asset values of proprietary providers when they are determined by appraisals.

Section 134.4 of HIM-15 provides that all assets, including assets not used in patient care, be included in appraisals, so that the correct amount of depreciation can be allocated to nonallowable cost centers to enable a proper allocation of administrative and general expense to the nonallowable cost centers. The section also requires that GAAP be used to determine whether improvements and betterments to fixed assets be amortized or expensed.

HCA COMMENT:

Finally, in the initial portion of the draft report's Introduction, the author notes that the intermediaries have not yet made a final determination regarding HCA's acquisition costs of HAI. While this statement is technically correct, it does not fairly reflect the extensive review made by HCA's fiscal intermediary, Blue Cross/Blue Shield of Tennessee and Blue Cross Association, which has been presented to HCFA for its approval. This acquisition occurred on August 26, 1981. Since that time HCA and intermediary representatives have had a number of meetings regarding the allowability of HCA's costs incurred in the acquisition. These meetings specifically covered the subjects of the debt allocation, goodwill allocation, debt discount and treatment of leases - all of which are addressed in some detail in the draft report. With respect to each of these matters, the fiscal intermediary has already made a detailed review of the facts, has required HCA to respond to a number of questions and provide additional data to support its claims for costs regarding these elements of the purchase and has approved the very costs which are criticized in the report. In fact, both Blue Cross/Blue Shield of Tennessee and Blue Cross Association have advised HCA that they approved HCA's entire reporting method of the HAI acquisition without any adjustment. These facts are mentioned to point out that extensive review already undertaken, and virtually completed, by the responsible Medicare program officials has resulted in acceptance of HCA's reporting of its HAI acquisition costs. To issue a report to Representative Gradison, without advising him of the actual, though not final, determinations already made is unfair.

GAO ANALYSIS:

While the intermediary has done substantial work related to treatment of the costs associated with HCA's acquisition of HAI, no final determinations have been made. In fact, the intermediary asked HCFA in July 1983 to provide policy guidance on all of the issues included in this report to enable the intermediary to make final determinations. Therefore, the intermediary has at most made tentative determinations about how the acquisition costs can be included for Medicare reimbursement purposes. Also, in commenting on the report, the Blue Cross Association said that it was still resolving the issues discussed in this report (see p. 44).

HCA COMMENT:

A. DESCRIPTION OF THE PURCHASE

In describing the purchase the draft report contains three errors which HCA believes should be addressed before a final report is issued. First, it singles out $6,000,000 in legal, accounting and other costs incurred in connection with the acquisition together with an additional $3,400,000 in severance pay to HAI employees. This is incorrect since the total amount paid for legal, consulting, professional accounting and severance and termination pay, together with costs described as "other costs" was under $6,500,000.

GAO ANALYSIS:

We obtained the figures used in the draft report from two sources that appeared to be mutually exclusive. After commenting on the draft report, HCA provided a list of the costs discussed here totaling $6,453,996. Therefore, we have changed the report to reflect this.

HCA COMMENT:

Second, the report indicates that HCA retired $80,000,000 in debt within four months of the acquisition when in fact the Company actually retired $100,000,000 of debt within that time period.

GAO ANALYSIS:

We used HCA's debt listings to arrive at the figure we used. After commenting on the draft report, HCA provided us a list of the debt it had retired by that date. The list showed that $89.2 million in debt had been retired and that the outstanding principal amount on the remaining debt had been reduced by $4.7 million through periodic payments for a total debt reduction of $93.9 million. The list also stated that $6.7 million in debt had been retained at the corporate office and not allocated to hospitals. We have changed the report to reflect these figures.

HCA COMMENT:

Third, the draft report refers to the "inappropriateness" of discounting assumed HAI debt (at 9). Although this subject is discussed on page 75 of this response, HCA calls your attention to the fact that for a number of years program policy has expressly recognized the allowability of costs associated with favorable financing. Describing the discounting of debt as inappropriate in the light of existing program rules is an unfair presentation to recipients of the report.

GAO ANALYSIS:

Medicare policy does not expressly recognize the allowability of discounting assumed debt. See the discussion related to HCA's specific comments on this issue on pages 76 and 77.

HCA COMMENT:

B. DETERMINATION OF LEGAL STATUTORY MERGERS

Since its inception Medicare has always recognized that hospital costs include cost of ownership of capital assets used to provide patient care. As the draft report properly recognized (at 4) the cost of capital assets may be revalued if there is an acquisition accomplished through the means of a statutory merger. Unfortunately, the draft report suggests that there may have been a prior relationship between HCA and HAI or its parent, INA Corporation. This is the type of gratuitous comment objected to above. The reference to related parties in the unsubstantiated, and virtually undiscussed, manner appearing in the draft report is inappropriate and should be deleted. Moreover, contrary to the report's statement that this issue was merely shifted back and forth between Blue Cross Association and HCFA, both these agencies, in fact, examined the question in some detail. HCA understands it was specifically reviewed by the Office of General Counsel of HCFA and that HCFA reviewed this question when it issued a letter stating that, in the words of the letter, "successful statutory mergers" occurred which would permit a revaluation of assets. For these reasons HCA requests that any reference to the possible existence of related parties in connection with this acquisition be removed from the final report.

GAO ANALYSIS:

We did not say that HCA and HAI were related; we said that the question was raised by the Blue Cross Association and was not answered by HCFA. However, because we did not specifically address this issue in our review, we have deleted reference to the question of relatedness in this section.

HCA COMMENT:

In addition HCA calls your attention to an erroneous reference to the Medicare regulation in footnote 2, page 4, of the draft report. The correct reference is 42 CFR §405.415(l)(2)(i).

GAO ANALYSIS:

The correct paragraph is (l) and not (k). The report has been changed to reflect this.

HCA COMMENT:

C. CHARGE VERSUS COSTS

HCA does not assert, as indicated in the draft report, that analysis of costs incurred as a result of the merger is of little value. In fact, HCA believes it is important for the Medicare and Medicaid programs to identify the costs of their policies. HCA suggests, however, that an accurate discussion of HCA's charge policies should be reflected as part of GAO's review since the auditor was supplied with examples of HCA hospital charge increases following the acquisition. These examples show that there were no concurrent charge increases and only moderate changes occurred in HCA's prices for hospital services during the next fiscal year - changes that were significantly less than inflation. Although HCA has absorbed the majority of its acquisition costs since charges were not generally raised to cover costs, this fact does not appear in the draft report.

GAO ANALYSIS:

Because HCA commented that it does not hold the same opinion as the HCA official cited in the draft report, we have deleted that official's opinion.

As we stated in the draft report, HCA determines the extent to which its charges reflect its costs. We deal primarily with costs in this report because costs can be uniformly measured, whereas the extent to which charges reflect costs can vary from hospital to hospital. Also, providers can change their charges at any time for any reason they choose, whereas costs change only when the prices a hospital pays change or operations at the hospital change.

However, because of HCA's comments, we have included on page 5 more information on changes in charges.

HCA COMMENT:

II. [Chapter 2]

EFFECT OF THE ACQUISITION

The draft report focuses on interest, depreciation and home office expenses, and suggests that these costs are somehow excessive, but does not point out that they were incurred consistent with Medicare reasonable cost criteria. Although HCA will not attempt to address all of the report's figures and computations appearing in Chapter Two, HCA believes clarification is required with respect to the following items:

(a) The amount of $55,000,000 in cost increases (at 8) includes interest on purchased goodwill of approximately $28,800,000 and no reimbursement is being claimed for this aspect of HCA's costs.

GAO ANALYSIS:

Chapter 2 discusses the overall increase in costs after the acquisition. HCA will have either to absorb these increased costs and thereby reduce its overall profits or to recoup the increased costs through higher payments by hospital users and/or their payors. Chapter 3 discusses the impact of the acquisition

on Medicare and Medicaid costs. In chapter 3, the issue of interest on goodwill and the amount of interest related to goodwill for which HCA did not claim reimbursement from Medicare and Medicaid is discussed. We have noted on page 9 that HCA did not allocate interest related to purchased goodwill to Medicare or Medicaid.

HCA COMMENT:

(b) In the discussion concerning DePaul Hospital it is misleading to indicate that debt increased from $71,000 to $2,400,000. In fact, what occurred was HCA properly capitalized the lease of DePaul Hospital under GAAP and HCA was limited to reimbursement of its owner's costs under HIM-15 §110B.

GAO ANALYSIS:

Again, chapter 2 addresses the overall impact on costs of the acquisition, and chapter 3 discusses the impact on Medicare and Medicaid. HCA's treatment of leases for Medicare purposes is discussed in chapter 3 at pages 31 to 33.

HCA allocated $2.4 million in debt to De Paul Hospital, so its costs as reflected in HCA's books will increase due to an increase in interest expense above that under HAI. However, to help assure that the differences between chapters 2 and 3 are clear, we have deleted the discussion of the lease related to DePaul Hospital.

HCA COMMENT:

(c) The estimated increase in depreciation expense of $8,400,000 (at 10) is technically correct but again may mislead its reader. This amount includes depreciation expense assigned to a number of medical office buildings and other assets that are not patient care related and for which reimbursement was not claimed on the hospitals' cost reports.

GAO ANALYSIS:

The $8.4 million estimated increase in depreciation expense includes depreciation related to the medical office buildings. With the records available we were unable to separate out the office buildings for HAI, so we included the depreciation for them in both the before and after acquisition estimates. However, the medical office buildings represent a relatively small portion of depreciation (4 percent) so including them should not distort the figures very much. Also, the report discloses that this estimate includes depreciation on the medical office buildings.

HCA COMMENT:

(d) It is improper to consider, as the draft report does, the acquisition costs in the year of the acquisition only. To evaluate the cost of the merger properly, its long-term benefits and costs must be considered. As one example, in 1981, when the acquisition occurred, HCA's effective interest rate incurred to acquire the HAI facilities approximated 16%. Since that time its effective interest cost has dropped approximately 3%. Thus, while the draft report indicates $62,500,000 in increased interest expense as a result of the merger, that number distorts the actual interest costs incurred because such costs were at their highest immediately following the acquisition and includes interest on purchased goodwill of $28,800,000.

GAO ANALYSIS:

The draft report pointed out that the cost increases related to the acquisition would not remain constant over time (see p. 8). Specifically, we pointed out that interest costs should decline over the years. To measure changes in costs, we had to select a period of time. The first year after acquisition was selected because, at the time of our fieldwork, data were available only for that period. Also, because HCA sold some of the hospitals about 15 months after the acquisition, it would not have been possible for us to determine the impact for a later period.

HCA COMMENTS:

(e) Finally, HCA does not believe the draft report adequately recognizes the economies of scale that have occurred from the merger. There are a number of savings projected as a result of the merger which are significant although difficult to quantify which were identified in HCA's report to the Justice Department given the GAO auditor.

GAO ANALYSIS:

The matter of possible operating savings was discussed in the draft report (see p. 13). As HCA states it is difficult to quantify any impact on costs that economies of scale may have had. We presented HCA's opinion regarding this issue.

HCA COMMENT:

EFFECT OF THE ACQUISITION ON COSTS AT TWO HOSPITALS

The draft report discusses cost increases at Lewisburg Community Hospital and Sequatchie General Hospital.

While the draft report's figures emphasize the increase in capital costs, it failed to disclose that the operating costs at these hospitals increased at a much lower rate than the national average. HCA attributes this to economies of scale. For example, the operating cost increases at Lewisburg Community Hospital were $23.00 per patient day, or 13% of operating costs while those at Sequatchie General Hospital amounted to only $4.00 per patient day or 3% of operating costs. These increases occurred at a time when hospital increases nationally exceeded 17%.

GAO ANALYSIS:

A comparison of the pre- and post-acquisition cost reports shows that operating costs (total costs minus capital costs) increased 12.7 percent per day at Lewisburg Community Hospital as HCA commented. However, our comparison for Sequatchie General Hospital showed an increase of 10.2 percent per day rather than the 3 percent stated in HCA's comment. During the first year after the acquisition, changes in hospital charges as measured by the Consumer Price Index's hospital and other medical services component increased by 14.5 percent. For fiscal year

1982, operating costs per day under Medicare increased by 15.2 percent.

We have included a discussion of changes in operating costs on page 15.

HCA COMMENT:

In summary, while capital costs have increased as a result of the merger, there are a large number of operating benefits not mentioned by the draft report's author. A distorted picture of the merger has therefore been presented. To mention depreciation increases of $8,400,000 without factoring out non-allowable and non-claimed costs is inaccurate. Finally, to discuss increases in interest expense without eliminating interest on the goodwill acquired, $28,800,000, for which no cost is claimed is improper.

GAO ANALYSIS:

As discussed under the specific comments related to chapter 2, we believe we have fairly presented the overall changes in capital costs related to the acquisition and presented HCA's position on operating benefits. Chapter 3 discusses HCA's claims for Medicare reimbursement for depreciation and interest.

HCA COMMENT:

III. [Chapter 3]

HANDLING SPECIFIC COST ITEMS ALLOCATED TO MEDICARE

The draft report is wrong in stating HCA used a number of methods which are not allowed by Medicare or which are questionable under Medicare principles. Both the fiscal intermediary and Blue Cross Association found that just the opposite was the case and, as noted earlier, the intermediary determined that no adjustments were appropriate. Unlike the draft report which is generally silent on discussing any particular Medicare rule, HCA will refer you to the appropriate Medicare principle with respect to each of the cost items under discussion. Moreover, as

indicated at pages 52-54 of this letter, the draft report's disregard of GAAP in determining Medicare costs is not correct and rather than using GAAP in only the rare instances suggested, it is in fact generally used for most Medicare principles.

GAO ANALYSIS:

We continue to question whether HCA's methods are in accordance with Medicare principles. Basically, as discussed in the GAO analyses related to the specific HCA comments, we believe that HCA misinterpreted certain Medicare reimbursement provisions or cited others that we believe are not relevant to the issue discussed.

HCA COMMENT:

DEBT AND RELATED INTEREST ALLOCATED BY HCA

In criticizing HCA's method of allocating debt to the acquired assets, a number of comments are appropriate. The first six comments below address the proper application of HIM-15 §203 to the merger and the last five comments address specific areas of the draft report discussion regarding the proper allocation of debt.

First, §203 was never intended to be applied at the home office level to costs incurred in a multi-hospital acquisition as the draft report implicitly recognizes (at 19-20) although it does apply at the provider level. Moreover, HCA does not believe it can practically be applied by the program to loan costs incurred at the home office level since HCA does not have a single intermediary servicing HCA facilities but has 14 separate intermediaries or fiscal agents for the former HAI facilities. The problems of applying §203 to home office debt incurred in a multi-hospital acquisition are accentuated because HCA operations are decentralized and it does not maintain detailed accounting records for each hospital at the corporate level. Therefore its home office fiscal intermediary does not know which assets are or are not patient care related at the various local providers.(*)

The home office intermediary does not have ready access to each facility's cost report and would have to review every HAI facility's cost report and deal with each local intermediary to work out the type of allocation of debt to assets that the draft

report suggests should occur. If the allocation were made as suggested by the draft report, each intermediary would separately determine the assets it claims are unrelated to patient care and if any intermediary adjusts the debt allocation at a local hospital it would require a revision of the entire, i.e., national, allocation of debt incurred to finance the acquisition. For this reason, HCA assigned debt equally to all facilities based on the ratio of each hospital's appraised value to total appraised fixed assets which permits each local intermediary to determine the allowable and nonallowable debt for each hospital. This approach was not only reviewed and tentatively approved by Blue Cross/Blue Shield of Tennessee on June 14, 1983, but a similar methodology for delineation of intermediary responsibilities for multi-facility acquisitions has been required by HCFA in other cases.

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* The difficulty of determining whether assets are related to patient care is alluded to by the draft report in footnote 3, page 20.

GAO ANALYSIS:

HCA states that the section 203 method applies at the individual hospital level but not at the home office, or aggregate, level. In our opinion, because section 203 applies at the provider level, it must also apply at the aggregate level. All we pointed out on pages 19 and 20 was that although section 203 is phrased in terms of the acquisition of a single facility, we applied section 203 in the aggregate because doing so was a logical interpretation of the requirements.

HCA's comment states that it is administratively easier to use its method to allocate costs to the providers and then apply section 203 at each provider. It is a matter of conjecture whether it is easier to go through section 203 at all 54 hospitals after allocating costs or to go through section 203 only once in the aggregate. Nevertheless, we believe section 203 should have been used to allocate costs to the providers because Medicare principles require this. Moreover, we note that in preparing the individual hospital cost reports, HCA did not use the section 203 method but merely included the figures allocated to the hospitals by its method.

Furthermore, we believe that in a transaction as significant and complex as the HCA acquisition of HAI, Medicare's administrative structure should be made sufficiently flexible to assure that the appropriate reimbursement rules are applied. We

believe the administrative effort necessary to accomplish this is justified because the acquisition will continue to affect Medicare costs for many years.

Regarding HCA's comment that an allocation methodology similar to the one it used had been required by HCFA in other cases, we asked HCA to provide us with the cases it was referring to. In response HCA provided a letter from HCFA's Office of Reimbursement Policy regarding HCA's proposed acquisition of another group of hospitals. HCA's representative had requested HCFA's opinion about whether that proposed acquisition would permit a revaluation of assets and an adjustment in equity capital. In response, HCFA said it could not render an opinion in this case because of the complexity of the transaction and because HCFA was unsure of the facts (HCA had said that the providers were partnerships while the intermediaries said that some of the providers were corporations). Therefore, HCFA said it would depend on the intermediaries to determine the allowability of revaluations. Because the case cited by HCA involved determinations about revaluation and not about debt allocation, we believe the case is not similar to the HAI acquisition and is not relevant to that acquisition.

HCA COMMENT:

Second, the method used by HCA to allocate debt was selected because of four reasons: (A) the method resulted in an allocation of debt that was consistent for all hospitals and one that would be easily verified; (B) the methodology was reasonable for management purposes since it placed all hospitals on an equal basis to evaluate operations; (C) it was accepted by HCA's auditors for financial statement purposes in accordance with GAAP, and was accepted by HCA's fiscal intermediary; and (D) since long-term debt is not in general used by HCA, or most businesses, to finance current assets or movable equipment such debt should not be allocated to these assets. These reasons, among others, were accepted by the intermediary in approving HCA's method of allocating its debt incurred as part of the merger.

GAO ANALYSIS:

Although all of the cited reasons may be valid from HCA's corporate accounting perspective, Medicare principles require that a section 203 allocation be made. Also, as noted before,

the intermediary has not determined whether it will accept HCA's method, and we believe it should not.

HCA COMMENT:

Third, in calculating the "savings" to Medicare computed by the report's author (at 19-22) the appraised value of the leases were deducted from the assets acquired. This is clearly incorrect since the purchase of the leases were, in fact, assets acquired to which values were assigned by [the appraiser], a nationally recognized appraisal firm, and HCA's treatment of the purchased leases was required by GAAP and Ernst & Whinney, HCA's independent auditors. The draft report does not suggest that it was improper to assign values to the purchased leases or to deem them to be acquired assets.(*) Every standard of which HCA is aware, including Medicare, GAAP, Defense Acquisition Regulations ("DAR") and tax either permits or requires purchased favorable leases to be assigned values and booked in the same manner as any other asset. See 42 CFR 405.415(g); HIM-15 §104.10; Accounting Principles Bulletin No. 16 §88(e); DAR §15-205.9(j) and IRS Reg. 1.162-11(a). These sections are discussed more specifically at pages 85-92 below which address the subject of valuing leases.

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* As indicated at pages 85-98 below, the draft report mistakenly assumed HCA revalued the assets of the leased facilities rather than the leases themselves.

GAO ANALYSIS:

The question we raised relates to whether HCA assigned the correct value to the acquired lease rights (see footnote 4, p. 21). HCA equated the value of the leased assets to the value of the acquired lease rights. In our opinion, this is inappropriate for Medicare cost reimbursement purposes. Our basis for this belief is presented in chapter 3 and in our analysis of HCA's comments about lease valuations presented in this appendix.

HCA COMMENT:

There is nothing in §203, or in any other Medicare rule, which supports the draft report's suggestion that intangible assets related to patient care should be subtracted for purposes of allocating debt. In fact, both §203 and the Medicare regulation at 42 CFR 405.419(d) specifically recognize that the owners' investment of funds used to acquire a facility will be applied to intangible assets.

GAO ANALYSIS:

We did not suggest that intangible assets should be subtracted for debt allocation purposes except for goodwill. We stated that the value of intangible assets can be included but said that the intangible value of the acquired lease rights was not the same as the value of the leased assets. (See pages 87 to 89 for a further discussion of the value of the acquired leases.)

Furthermore, the regulation cited by HCA states that:

> "In determining whether a loan was made for the purpose of acquiring a facility, we will apply any owner's investment or funds first to the tangible assets, then to the intangible assets other than goodwill and lastly to the goodwill. If the owner's investment or funds are not sufficient to cover the cost allowed for tangible assets, we will apply funds borrowed to finance the acquisition to the portion of the allowed cost of the tangible assets not covered by the owner's investment, then to the intangible assets other than goodwill, and lastly to the goodwill.

Thus, the regulation cited by HCA is consistent with and supports the allocation method called for by section 203 and used by us.

HCA COMMENT:

Fourth, although §203 does not apply to debt allocated among a number of hospitals acquired in a single transaction, HCA does agree that it applies at the provider level. HCA believes no program savings would result from such effort and this may have been a reason the fiscal intermediary agreed with HCA's

debt allocation approach. The lack of any savings is particularly apparent from the fact that HCA assigned debt to finance 100% of its acquired goodwill (and claimed no interest on this part of its debt) together with the fact that it is inappropriate to deduct purchased leases from the total appraised value of assets in allocating debt.

Fifth, nothing which appears in the draft report supports the author's conclusion about "savings" if strict compliance with §203 occurred at the hospital level. HCA does not believe the GAO auditors examined the data sufficiently to determine the amount of costs that would be increased or decreased by reason of a technical application of §203. If such a savings in fact exists, and HCA suggests that it does not because of offsetting increases in return on equity, it has not been determined. Accordingly, HCA believes great care should be taken in advising Representative Gradison of GAO's belief as to any "savings" from the application of this section.

GAO ANALYSES:

For the reasons cited previously, we believe section 203 applies to debt allocation in the aggregate. As pointed out in the report, Medicare requires that debt be assigned to goodwill first, and HCA followed this debt assignment requirement for the goodwill it calculated. Also, as stated in footnote 6 on page 22, using the section 203 method substitutes a Medicare return on equity payment for an interest payment. In this case, however, the allocable costs would be lower using section 203 and Medicare payments would be lower.

Because HCA did not consider equity (that is, the value of the stock used in the transaction) in its allocation method, we cannot use its figures to determine the effect of return on equity on the application of section 203. Instead, we have estimated the overall effect using the following procedure.

Equity for Medicare purposes is basically the difference between assets and liabilities. Because of the many changes after the date of acquisition (resale of hospitals, retiring of some assumed debt, etc.), we have estimated the difference in total allocable interest and return on equity between the section 203 method and HCA's method as of the day of acquisition on an annualized basis. The following illustrates the calculations.

Section 203 Computation of Allocable New Debt on 8/27/81

Total value of acquired assets related to patient care	$672.3 million
Less appraised value of leased hospitals	191.3 million
Adjusted value of acquired assets related to patient care	481.0 million
Less investment by HCA (value of stock)	190.0 million
Total debt allocable	291.0 million
Less assumed debt	270.0 million
Total new debt allocable	$ 21.0 million

Computation of Allocable Increase in Equity on 8/27/81

Total value of acquired assets related to patient care	$672.3 million
Less acquired value of leased hospitals[a]	191.3 million
Total value of acquired assets eligible for return on equity	481.0 million
Less assumed debt	270.0 million
Total increase in assets	211.0 million
Less allocable new debt	21.0 million
Net increase in equity	$190.0 million

[a]Section 1218.8 of HIM 15 requires that the value of all leased assets be deducted before computing return on equity.

Computation of Allocable Interest and Return on Equity

Net increase in equity	$190	million
Times the Medicare rate of return on equity for the period Sept. 1981 - Aug. 1982	20.625	percent
Total allocable return on equity	$ 39.2	million
Total new debt allocable	$ 21.0	million
Times average rate of interest paid by HCA	16.3	percent
Total allocable interest	$ 3.4	million

Thus, total allocable return on equity and interest using the section 203 method would have been about $42.6 million. However, HCA's December 31, 1981, allocation of debt, the first complete allocation we identified, resulted in $300 million in new debt being allocated at an annualized interest expense of about $48.9 million for the first year after acquisition. Therefore, we estimate that using the section 203 method would result in $6.3 million less in allocable interest and return on equity than using HCA's method.

HCA COMMENT:

Sixth, the report is correct in stating HCA did not consider the value of other assets (i.e., current assets or major movable equipment) in the process of allocating debt. These assets were excluded from consideration because, in general, long term debt is not used to finance current assets or major movable equipment and, in fact, it was not done here.

GAO ANALYSIS:

In addition to current assets and major movable equipment, HCA also did not consider the value of the hospital management companies it acquired or the contracts with hospitals they had, the value of any of the other corporate entities acquired, the

value of certain vacant land, etc. If HCA were permitted to allocate debt by the method it chose, values would have to be assigned to all these other assets so that debt could be properly allocated to them. Use of the section 203 method negates having to assign values to such other assets because they generally are not related to patient care. Therefore, we did not discuss in the draft report the issue of the value of other assets because it was not necessary when we applied section 203.

HCA COMMENT:

Seventh, the draft report implies that debt of $595,000,000 was allocated to fixed assets of $530,000,000 which over-allocated debt to the value of the assets acquired (at 19). This was not the case because there was over $180,000,000 of goodwill acquired over and above the purchased fixed assets and all of the goodwill was considered to be financed with debt. The draft report should, therefore, be clarified to avoid any misconception on this matter.

GAO ANALYSIS:

The draft report clearly stated that HCA (1) deducted $140 million of debt for goodwill in its January 1982 allocation of debt to the hospitals and (2) later increased to a total of $180.9 million its allocation of debt to goodwill (see p. 19), although this revised allocation had not been reflected in the hospital cost reports.

HCA COMMENT:

Eighth, at page 20 the draft report states that in March, 1983, nineteen months after the acquisition, HCA submitted a revised purchase price to the intermediary. This statement is mistaken because there was no revision of the purchase price, although a revision of the allocations of the purchase price was not finally determined until nineteen months following the merger. Moreover, the delays incurred in making final determinations regarding allocations are normal business practices and not unusual in complex acquisitions.

GAO ANALYSIS:

HCA is correct in that its letter did not contain a revised purchase price. Rather, it revised the amount of goodwill purchased from the $140 million used by HCA in its January 1982 allocation of debt to a new value of $180.9 million. This was discussed later in the chapter. The reference on page 20 has been changed to clarify that this was HCA's report of a purchase price to the intermediary and that it included a revised valuation of goodwill from that previously used to allocate debt.

HCA COMMENT:

Ninth, although HCA allocated over $180,000,000 in debt to goodwill (not $140,000,000 as the draft report states) and over $13,000,000 to the medical office buildings, no interest is claimed as a cost on this part of the debt and the draft report should be clarified to recognize this point.

GAO ANALYSIS:

The draft report clearly indicated that interest related to the amount of purchased goodwill was not included on the hospitals' Medicare cost reports. We used the $140 million of goodwill figure because this was the amount used to allocate debt to the cost reports. The change to $180.9 million in goodwill may well necessitate revising the cost reports.

HCA COMMENT:

Tenth, in considering new versus assumed debt the total issued and assumed debt was allocated equally to all of the acquired hospitals based on the ratio of the specific hospital's appraised fixed assets to total appraised fixed assets. The allocated debt was reduced by the assumed debt recorded on each acquired hospital's books to arrive at the additional amount of debt to be assigned to each hospital. This resulted in an equal ratio of debt to fixed assets being assigned to each hospital. The reasons new and assumed debt was pooled in this manner before being reallocated are the same as those set forth in paragraph Second above and these reasons were accepted by HCA's fiscal intermediary.

GAO ANALYSIS:

HCA did allocate the debt as stated, and we discuss the comments related to the reasons for doing it in this manner on pages 24 and 25. We believe that the assumed debt, because it was a preexisting liability, should be deducted first, provided the debt is related to patient care.

HCA COMMENT:

Eleventh, in its discussion of Emerson A. North Hospital in Cincinnati, Ohio, the GAO auditor was faced with the very problem identified above, namely that one cannot guess whether assets relate to patient care or not. This is a subject best left to each hospital and its intermediary. For example, HCA has verified that the monkey house alluded to by the report's author was originally a research center but is now used for hospital storage purposes. HCA believes it would be appropriate to delete the unsupported comments relating to Emerson A. North Hospital from any final report. Similarly, the reference to "an abandoned hospital" (Hillsboro) is gratuitous since no cost was ever claimed by HCA in connection with the part of the purchase price allocated to that facility.

GAO ANALYSIS:

This section was included to indicate that HCA should make a review of the assets to identify those that are not related to patient care. This should be done before subtracting the allowable cost of the assets related to patient care from the purchase price to identify the allowable debt. We did not state that HCA claimed costs for the abandoned hospital.

In regard to Emerson A. North Hospital, we have deleted reference to the monkey house but continue to identify three other buildings identified as vacant in the appraisal. These are used in the report as examples of assets that appear to be unrelated to patient care.

HCA COMMENT:

ASSUMED DEBT WAS DISCOUNTED

The draft report correctly states that a portion of the debt which HCA assumed as part of the HAI acquisition was discounted. This part of the report is incorrect, however, on two basic points, namely that discounting of debt results in a non-reimbursable imputed cost being claimed as reimbursable interest expense and that Medicare does not allow costs associated with the discount to be reimbursed.

The GAO report states that the discounted debt was an "imputed" cost. This is incorrect because HCA actually purchased facilities under favorable financing terms at the time of the acquisition which was a purchase price factor. The value assigned to the acquired debt was in accordance with Accounting Principles Bulletin ("APB") Opinion No. 21 which states that the use of an interest rate which varies from the prevailing interest rate requires an allocation of a portion of the purchase price to favorable financing. Thus, the cost of the favorable financing associated with HAI debt was not an imputed cost but was an actual cost incurred by HCA and was reflected on its financial statements in accordance with GAAP.

More importantly, Medicare has allowed costs of discounted debt in similar situations on at least two occasions. In the first case, St. John's Hospital and Health Center v. Blue Cross Association, PRRB Dec. No. 77-D58R, CCH Medicare and Medicaid Guide [1979-1 Transfer Binder] §29,436, recognized the allowability of costs associated with the favorable purchase of existing debt on an acquired facility. This decision was not modified or reversed by the Administrator of HCFA. In the second case, Las Olas General Hospital v. Blue Cross Association, PRRB Dec. No. 79-D62, CCH Medicare and Medicaid Guide [1979-2 Transfer Binder] §30,156 the PRRB reiterated the decision reached in St. John's Hospital and Health Center. This case was affirmed by the Administrator of HCFA who, relying on APB Opinion No. 21, held that the amount paid to obtain favorable financing constituted deferred financing to be amortized over the length of the financing and reimbursed by Medicare. HCFA Administrator Decision, December 4, 1979, Las Olas General Hospital v. Blue Cross Association, CCH Medicare and Medicaid Guide [1980 Transfer Binder] §30,323.

The draft report is incorrect, therefore, in its conclusion that costs associated with discounted debt are not allowed by Medicare. Under these circumstances HCA suggests that this portion of the draft report be deleted.

GAO ANALYSIS:

Medicare law (42 U.S.C. 1395x) states that to be considered reasonable a cost must be "actually incurred." Medicare regulations (42 C.F.R. 405.419) also require that interest be incurred to be an allowable cost. Therefore, clearly, a provider must demonstrate that it has actually incurred an interest expense in order to claim reimbursement for it.

The discounting of interest represents an imputing of costs; therefore, HCA must demonstrate that it has actually incurred a cost before it can claim the discount as an allowable cost for Medicare purposes. We do not believe that HCA has met this burden. HCA states that being able to assume debt at lower than market rate at the time of acquisition "was a purchase price factor." HCA assigned a value to these lower rate loans equal to the difference between the present value of the loan and the amount that will eventually be paid. However, HCA has not provided any documentation demonstrating that the lower than market rate loans actually were a purchase price factor or showing the amount of consideration paid specifically because it was able to assume the lower rate loans. In fact, as discussed on page 25, HCA even computed a discount on the "debt" related to capitalized leases. Capitalizing a lease results in the entry of debt in accounting records, but this is not a loan.

The two Provider Reimbursement Review Board decisions and the HCFA Administrator's affirmation of one of them, which HCA cites as "similar situations" that support its position, are, in fact, dissimilar. Also, these decisions support our position that providers must demonstrate that they actually incur an interest expense.

First, the situations involved in these cases are dissimilar. Both involved seller financing of a purchase, not assumption of a loan. The providers were able to demonstrate that they had paid more than fair market value for the facilities because the seller agreed to finance the purchase at less-than-market interest. The Review Board termed this "prepaid interest" in one case and "deferred financing" in the other.

Second, the HCFA Administrator's decision states that the provider must demonstrate "the existence of interest expense" and that it "cannot be automatically implied." The Administrator held that:

". . . a provider must furnish sufficient evidence to support, as a finding of fact, that the consideration given in exchange for favorable financing was interest expense. In this case the [PRRB] found the evidence convincing to this effect."

HCA COMMENT:

DETERMINING ASSET VALUES

HCA agrees with the draft report that it is important to correctly value the purchased assets (at 27). The reasons to do so extend beyond Medicare considerations. HCA is highly concerned that the price it pays for groups of assets be correctly stated for management, internal accounting, financial reporting and tax purposes as well as for Medicare. An independent appraisal firm was engaged by HCA to properly value the assets and the appraisal values have been accepted by HCA's independent auditors. For these reasons HCA believes that the suggestion that HCA's method of assigning values to assets is "questionable" should be very carefully reviewed by GAO authorities.

The draft report discusses four areas which it asserts raises questions as to the correctness of determining asset values:

(1) The appraiser was not independent;

(2) Different lives were used in appraising acquired assets and depreciating them;

(3) No salvage value was used; and

(4) Leased property was improperly revalued.

GAO ANALYSIS:

See analysis of specific comments below.

HCA COMMENT:

THE APPRAISER'S INDEPENDENCE

The appraiser used by HCA was [name deleted] one of the leading hospital appraisal firms in the country. The firm has national recognition, is used by a large number of hospitals all over the U.S., and has never been associated with HCA in any but a professional consulting capacity. [The firm's] president has been accepted as an expert appraiser by the PRRB and by various intermediaries and HCA is informed the firm in fact has been engaged to do appraisal services for fiscal intermediaries.

Moreover, [the firm] advises HCA that its billings to HCA comprise between 2% and 3% of its revenue between 1979 and 1983. Under these circumstances the appraiser's independence is difficult to question.

GAO ANALYSIS:

We did not question whether the appraiser was related to HCA by common ownership or control.

HCA COMMENT:

The basis for the draft report raising the question of the independence of the appraiser is because, according to the report, [the appraiser] modified its appraisal report at HCA's request to change the values assigned to the HAI hospital building services equipment. This is not correct and the actual facts show the following:

(A) In its preliminary report [the appraiser] allocated values to various components of HAI's facilities including walls, ceilings, floors, architects' plans and such fixtures as electrical, mechanical and heating, venting and air conditioning.

(B) These allocations were reviewed by HCA and by Ernst & Whinney, HCA's independent auditors, who noted the allocations were inconsistent with HCA's accounting practices.

(C) HCA's accounting practice requires that the labor and material portion, roughly 50%, of such items as conduit, stand pipes, duct work, etc., be assigned to the structure since they represent costs not usually replaced during the life of the building. This accounting policy is considered to be a very conservative one since if such items were deemed 100% a part of fixtures they would be depreciated at a significantly higher rate for tax and Medicare purposes.

(D) To consistently report the allocation of the purchase price between fixtures and structure for HAI acquired hospitals with other HCA hospitals, Ernst and Whinney recommended that to the extent the [appraiser's] preliminary report did not follow HCA accounting practice, it should be revised.

(E) The reclassification of a portion of the values assigned to fixtures to the building structures did not change the total values in the final report with respect to any specific facility but did shift about $100,000,000 from building services equipment to buildings. This revision had the effect of lowering the amount of depreciation which could be taken for Medicare and tax purposes since the increased amounts allocated to the structures would have to be depreciated over longer periods.

That [appraiser] amended its appraisal report to conform to HCA accounting policy, and did so because the company's independent auditors recommended it, is no basis to question the appraisers' qualifications.

GAO ANALYSIS:

We questioned the independence of the appraisals because the appraiser changed at HCA's request the allocation of depreciated reproduction cost between two classes of assets. In our opinion, an appraiser should independently determine the value of the assets and report its findings to its client. If the client believes that the appraisal is not consistent with its policies, the client should be responsible for reporting the changes to the appraisal report and justifying them. In this case, the client (HCA) asked the appraiser to change the appraisal so it would conform to the client's policies. Although HCA's reasons for wanting the appraisal changed may be valid under its accounting policies, we believe that the appraiser should not have changed its report. HCA should have made the

changes itself and justified them. This would have raised the issue for the intermediaries, which could have then objectively analyzed the justification. As the case was, the appraiser did not even disclose in its final report that the changes had been made.

We reviewed "The Principles of Appraisal Practice and Code of Ethics" of the American Society of Appraisers to see what it said about this issue. These principles state that the numerical result of an appraisal:

> ". . . is objective and unrelated to the desires, wishes, or needs of the client who engages the appraiser to perform the work. The amount of this figure is as independent of what someone desires it to be as a physicist's measurement of the melting point of lead . . ."

In discussing the appraiser's primary obligation to the client, the principles state:

> "The appraiser's primary obligation to his client is to reach complete, accurate, and pertinent conclusions and numerical results regardless of the client's wishes or instructions in this regard."

HCA also said the changes were made to a "preliminary report." Our review of the report found no indication that it was a preliminary report. The Principles of Appraisal Practice state:

> "If an appraiser makes a preliminary report without including a statement to the effect that it is preliminary and that the figures given are subject to refinement or change when the final report is completed, there is the possibility that some user of the report, being under the impression that it is a final and completed report, will accord the figures a degree of accuracy and reliability they do not possess. The results of such misplaced confidence could be damaging to the reputation of professional appraisers, generally, as well as of the appraiser concerned. To obviate this possibility, the Society declares it to be unprofessional appraisal practice to omit a proper limiting and qualifying statement in a preliminary report."

The appraiser told us that it was his understanding that the first report was prepared for Medicare purposes and that the revised report was for HCA's internal accounting purposes.

Page 84 presents an analysis of the effect of the appraiser's revision on the depreciable base for HCA.

HCA COMMENT:

Finally, the draft report refers to an HCA official (at 28) who stated that the preliminary values assigned to building services equipment were too high. This attribution to the HCA official is incorrect and was not the basis for the final appraisal report.

GAO ANALYSIS:

This statement was made to us by a senior HCA official. However, because in these comments HCA said this is not its position, we have deleted the statement from the final report.

HCA COMMENT:

IMPACT OF USEFUL LIFE ESTIMATES

In its discussion of the proper useful life to be used in valuing the acquired assets, the draft report suggests HCA was limited to American Hospital Association ("AHA") useful life guidelines unless approval was obtained from the fiscal intermediary for a different useful life. In a footnote, however, the report recognizes that providers may also use IRS useful life guidelines.

For reasons which are not clear to HCA, the draft report implies AHA guidelines rather than IRS guidelines are more appropriate. Although AHA useful life guidelines could result in different depreciated reproduction costs, this is irrelevant to HCA's acquisition since the appraiser was entitled by Medicare program rules (HIM-15 §104.17) to use allowable useful life guidelines published by the IRS to determine the asset values.

GAO ANALYSIS:

The manual section (104.17) cited by HCA pertains to the useful life of depreciable assets for computing depreciation as a reimbursable cost under the Medicare program. The manual sections dealing with appraisals are 104.12 and 134, and the former states that the book value of an asset at the appraisal date is its appraised costs as of the date of acquisition less accumulated depreciation computed on any approved basis up to the appraisal date. The permissibility of using AHA guidelines was stated in the body because the appraiser in his appraisal reports to HCA stated that those guidelines were used in determining asset value. When the appraisal reports were revised to reflect the reallocation of depreciated reproduction costs to the buildings category, the appraisals generally dropped the reference to the AHA guidelines and did not cite any specific set of guidelines. When we asked the appraiser, he said AHA guidelines were used and provided a copy of the 1961 revision of the 1959 guidelines. That edition of the guidelines was not allowable for Medicare purposes, and neither the 1973 nor the 1978 edition includes the useful lives used by the appraiser.

In any event, HHS regulations (42 C.F.R. 405.415(b)) published in the Federal Register on August 18, 1983, provide that Internal Revenue Service guidelines can be used only for assets acquired before January 1, 1981. Accordingly, because the assets discussed in this report were acquired in August 1981, any references to those guidelines are now moot.

HCA COMMENT:

With respect to depreciation the report states that HCA did not use IRS guidelines. While this is so HCA depreciated HAI acquired assets in a manner consistent with the company's written depreciation policies which have been reviewed and accepted by the Medicare fiscal intermediary and HCA's independent auditors. These policies are also consistent with industry guidelines. The independent appraisers' selection of useful lives for purposes of determining values has no application to the company's written depreciation policies which have been in place for a number of years. Those policies, which are implemented for purposes of consistency in presentation in the financial statements of all assets and which are required for management purposes, are not changed for each acquisition undertaken by HCA. If this were not the case, the company would be required

to have a number of different depreciation policies on useful lives of assets depending on who valued acquired assets and the valuation policy applied. HCA does not believe this would be acceptable either to its independent auditors or to Medicare auditors. Thus, the suggestion that HCA used questionable policies in its useful life estimates should be omitted from the final GAO report.

GAO ANALYSIS:

We did not suggest that HCA used questionable policies in its useful life estimates. In fact, we believe the estimated useful lives HCA used for depreciating its assets are consistent with Medicare policy. We merely pointed out that the useful lives used to appraise the assets and to depreciate them were different and that this had the effect of increasing Medicare costs. Although we have not identified any specific Medicare policy requiring that consistent useful life estimates be used to appraise and depreciate assets, it makes sense to us to use the same lives for both processes. Moreover, section 134.10 of HIM 15 states that the intermediary "will make the final decision as to the acceptance of the appraisal results for Medicare purposes." We believe that the intermediary should not accept the appraisals involved in this acquisition because the appraiser did not use useful life estimates approved by Medicare.

A 50-year life was used for computing the depreciated reproduction cost of both buildings and building services equipment, while a 40-year life for buildings and a 20-year life for building services equipment were used for depreciation purposes. Use of these inconsistent methods resulted in assigning a higher value to the assets, which in turn resulted in (1) higher interest costs being allocated to the assets and (2) greater depreciation being claimed over the assets' life.

The overall difference in depreciated reproduction cost between the two useful life estimates is:

Appraiser's depreciated reproduction cost based on 50-year life	$442.4 million
Depreciated reproduction cost based on 40/20-year life	365.1 million
Difference	$ 77.3 million

Thus, using the appraiser's method increased the asset values used to allocate debt and interest by $77.3 million over what would have been allocated using the 40/20-year life method. The appraiser's method also provided an additional $77.3 million for the depreciation base.

When at HCA's request the appraiser shifted depreciated reproduction cost from building services equipment to buildings, it reduced the difference between the two methods of calculating depreciated reproduction cost to $59.1 million as follows:

Adjusted appraiser's depreciated reproduction cost based on 50-year life	$442.4 million
Depreciated reproduction cost after appraiser's adjustment based on 40/20-year life	393.3 million
Difference	$ 49.1 million

The shift in values between the two asset classes would have the effect of increasing the depreciable base that is used for debt allocation and depreciation by $28.2 million ($393.3 million minus $365.1 million) above that which would have been calculated using Medicare-approved useful life estimates on the original valuations.

HCA COMMENT:

SALVAGE VALUE

As the draft report states, no salvage value was assigned to HAI acquired depreciable assets. However, the report is incorrect in stating salvage value was not considered (at 30). It was considered and was applied in a manner that was consistent with industry-wide practices as well as HCA internal practices. The hospital industry does not as a practice assign salvage values to depreciable assets and depreciation is almost always computed without regard to this component. HCA believes that GAO can easily verify this with any fiscal intermediary. Moreover, salvage value does not, in general, exist because of the practice of exhausting the usefulness of assets before disposition. As a result, predictable salvage value is negligible and

is generally exceeded by the cost of disposition. In those instances where an asset is disposed of prior to exhaustion of its useful life an appropriate adjustment is made at the time such disposition occurs.

GAO ANALYSIS:

We have modified the report to indicate that HCA said it considered but did not compute salvage value because it said the hospital industry as a rule does not assign salvage values to depreciable assets and depreciation is almost always computed without regard to this component. However, the regulation is quite clear. In discussing straight-line depreciation section 405.415(b)(3) states that the cost or other basis of the asset, less its salvage value, if any, is determined first. Then this amount is distributed over the asset's estimated useful life.

HCA COMMENT:

LEASE VALUATIONS

As part of its acquisition HCA acquired lease rights to fourteen hospitals leased by HAI. All of these hospitals were capitalized leases for accounting purposes, although Medicare classified six leases as virtual purchases (HIM-15 §110B) and eight leases as operating leases.

These lease rights were revalued along with all other HAI assets acquired through the merger. The draft report asserts that such revaluation was "questionable" because HCA did not own the assets of the leased facilities (at 21, 27, 31-32).

HCA believes the draft report's author has fundamentally misunderstood the transaction regarding the revaluation of leases. The draft report refers to a revaluation of leased assets not to a revaluation of leases. For example, at page 21 of the draft report it states "obviously the value of the hospitals' assets cannot be assigned to HCA because it does not own the hospitals"; at page 27 the report states "leased property was revalued"; at page 31 it captions its discussion "(l)eased assets not properly valued" and states "(r)eal assets . . . were . . . revalued without regard to whether HCA . . . merely acquired the right to use the assets through leases"; and at page 33 it concludes "a clear distinction needs to be made between owned assets and those used under operating leases."

Since the leased assets were not revalued, except as a means to determine the values of the leases, this basic error should be corrected throughout the report.

GAO ANALYSIS:

The appraiser determined the value of the leased assets, not the value of the leases. No distinction was made by the appraiser whether the appraised assets were leased or owned. In fact, the appraiser's report to HCA stated that:

> "No investigation of legal fee or title to the properties has been made and owner's claim to the properties has been assumed valid. No consideration has been given to liens or encumbrances which may be against the properties."

HCA equated the value of the acquired lease rights to the value of the leased assets, and that valuation method is what we are questioning.

HCA COMMENT:

There is no question that acquired leases may be revalued to reflect their actual fair market value at date of acquisition. HCA's fiscal intermediary agreed that all of the acquired leases are valuable assets and approved HCA's method of valuation. The leased property was appraised in accordance with §405.415(g) of the Medicare regulations and APB Opinion No. 16 in order to determine the value of the acquired leases. The value of the leases as recorded by HCA for the leased assets was then deducted from the appraised value to determine the value of the acquired leases. The step-up in value, i.e., the excess of the appraised value over the original values assigned to the leases by HAI, has been recorded in HCA's records for financial reporting, tax and Medicare purposes. This procedure has been audited and accepted by HCA's independent auditors.

That the leases constituted valuable property rights in themselves is clear. As indicated, all were capitalized and appear as assets on HCA's financial statements. For Medicare purposes, however, eight of the leases did not meet the virtual purchase requirements of HIM-15 §110B. Even these leases granted rights to the lessee approximating the rights of fee ownership. Each lease was for an extremely long term. Five of

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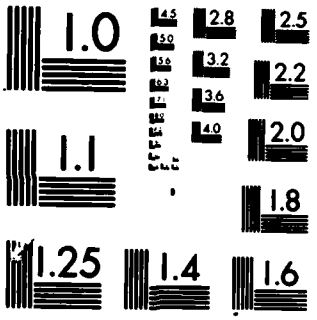

these leases had terms in excess of 50 years (one for 99 years), two had a term in excess of 45 years and one was for 30 years. Each lease except two included an option to purchase by the lessee and one of the remaining leases contained a right of first refusal which could be exercised by the lessee. Accordingly, the lessee obtained significant property rights which exceeded in virtually every case the useful life of the property itself.

Medicare regulations require revaluation of leases acquired as part of a purchase. Section 405.415(g) provides for the valuation of all assets acquired as part of the purchase of an ongoing facility. The purchase price must therefore be allocated to all assets, including leases. This section does not exclude intangible assets from the determination of the assets acquired.

GAO ANALYSIS:

The regulation (405.415(g)) cited by HCA refers to "depreciable assets acquired after July 31, 1970." Section 104.1 of HIM-15, which defines depreciable assets, states that "assets which a provider is using under a regular lease arrangement would not be subject to depreciation by the provider." Thus, the regulation HCA cited is not as clear cut on this point as HCA indicates it is.

We did not question that the leases could have some intangible value but rather the value HCA assigned to them. HCA assumed that the value of the acquired lease rights was equal to the value of the leased assets less rent, and we do not believe this is reasonable.

As stated in footnote 4, page 21, we believe that the provisions of the leases themselves must be considered in determining the value, if any, of the acquired lease rights. For example, we do not believe a lease that has rental payments fully indexed to inflation would have any intangible value because the increases in rent would keep the rental payments equal to the going rate for a similar lease.

In our opinion, the value of the acquired lease rights would be equal to the savings in rental payments available under the lease compared to what it would cost to lease a similar hospital of the same age in a similar location. Because of the small number of hospital leases entered during any period, it would be virtually impossible to determine the fair market value of a lease meeting these conditions. Therefore, we believe one must look at the terms of a lease to determine if HCA benefited by acquiring the lease rights under it.

Capital costs are the costs that must be incurred to use a facility; therefore, such costs to the owner are taxes, insurance, utilities, maintenance, repairs, depreciation, and interest. A lease is designed to recover these costs plus a profit for the owner. Benefits would accrue to a purchaser from acquiring lease rights that protect it from increases in those capital cost items. We reviewed the leases to ascertain the degree of protection against increases in capital cost items they provided to HCA.

All 14 leases require the lessee (HCA) to pay all property and other taxes as well as to insure the facility against loss and to pay all utilities. Thus, the lessee was not protected against increases in these costs, and the acquired lease rights would have no benefit relating to these cost items.

All 14 leases require the lessee to pay for all maintenance of and repairs to the building, building services equipment, and land improvements. Therefore, the lessee is not protected against any costs associated with maintenance and repair. In fact, leasing an older building under these terms could be a disadvantage because maintenance and repair expenses usually increase as a building ages.

All 14 leases require the lessee to pay for any improvements (such as additional buildings or additions to buildings) made to the facility, but the lessor gets ownership to the improvements. Again, the lessee is not protected.

Finally 11 of the 14 leases contain provisions that result in automatic increases in the rental payment amounts as follows:

--Under three leases, rent increases are based on the percentage increase in the Consumer Price Index.

--Under four leases, rental amounts are increased by specified amounts after specified periods. For example, at one hospital, the basic rent payments were to remain constant for the first 10 years and then increase by about 17 percent. At another hospital, the rent was to increase about 8 percent after 12 years, go up another 7 percent 2 years later, and increase another 7 percent 2 years after that.

--Under one lease, rents increase by specific amounts during the first 25 years of the lease and then increase by the percentage change in the Consumer Price Index. The lease had been in effect about 9 years.

--Under one lease, rents increased by specific amounts during the first 30 years of the lease and then the lessor was also paid a percentage of hospital revenues. The lease had been in effect about 8 years.

--Under one lease, in addition to a fixed rent, the lessee paid a percentage of hospital revenues to the owner.

--One lease included a schedule under which rent increased by a predetermined amount for the first 9 years and then decreased.

In our opinion, most of these rent escalation clauses gave the lessee little protection.

After reviewing the leases, we believe that HCA received little benefit from acquiring the lease rights because it gained little protection against increases in the items associated with capital costs. HCA's assigning the appraised value of the leased assets less rent as the value of the acquired lease rights is, in our opinion, out of line with the benefits it received.

HCA COMMENT:

Moreover, the payment of additional amounts to acquire lease rights is supported by HIM-15 §104.13. This section recognizes that the historical cost of assets under a lease-purchase arrangement is "the sum of lease payments and any additional payments made to acquire the assets, excluding the amount allowed as rent during the period of the lease or rental agreement." The additional payments made by HCA to HAI to acquire the lease rights to the 14 facilities are within the scope of "additional payments made to acquire the assets" contemplated by this section.

GAO ANALYSIS:

Section 104.13 deals with establishing the historical cost of an item acquired under a lease-purchase agreement after title to the asset has transferred to the provider. Because title has not been transferred on any of the leased hospitals classified as virtual purchases, we believe the cited section is not relevant to the valuation of the assets in general or to acquired lease rights in particular. Moreover, as stated previously we

do not believe HCA has demonstrated the value of the acquired lease rights or the consideration paid for them.

HCA COMMENT:

Further, in defining "historical cost" HIM-15 §104.10 expressly includes "costs that would be capitalized under generally accepted accounting principles." Thus, GAAP directly applies to lease acquisition costs in situations where those costs are properly capitalized. The relevant GAAP principle is found in APB Opinion No. 16 "Accounting for Business Combinations" which sets forth the controlling accounting principles for the merger of HAI into HCA.

Paragraph .88(e) of APB No. 16 provides:

"Intangible assets which can be identified and named, including contracts, patents, customer and supplier lists, and favorable leases (are assigned amounts) at appraised values."

The Opinion further provides that fair values are to be ascribed to specific assets and identifiable assets are not to be included as part of goodwill. See footnote 13 of APB No. 16.

GAO ANALYSIS:

Section 104.10 deals with determining the historical cost for depreciation purposes of "owned" assets and, as stated before, (see p. 54) places limitations on the use of GAAP for establishing historical costs. Also, section 104.1 defines depreciable assets as those that a provider has an economic interest in through ownership and states that assets which a provider is using under regular lease arrangements are not depreciable.

In addition, as stated before, the appraiser did not appraise the value of the acquired lease rights but rather appraised the depreciated reproduction cost of the leased assets (see p. 86).

HCA COMMENT:

Further support for valuing acquired leases can be found in the PRRB decisions recognizing Medicare's share of costs associated with favorable financing discussed above at page 75. Those PRRB cases also involved the valuing of acquired liabilities which had favorable terms. Moreover, one court case has addressed the reimbursement principles in this area. In that case, Spokane Valley General Hospital v. Schweiker (9th Cir. 1983) 697 F.2d 848, 850, the Court rejected the government's claim that no revaluation of assets could occur in an acquisition of a lease. It specifically ruled that Medicare's recognition of goodwill purchased prior to 1970 is not foreclosed by the fact the provider was leased rather than purchased because "the party operating the hospital benefits from the goodwill whether it leases or buys the underlying physical facility". Id. at 850.

GAO ANALYSIS:

The case HCA cited does not deal with leases but with a stock acquisition and subsequent merger and whether goodwill should be recognized (the case involved a pre-1970 transaction when Medicare recognized goodwill as an allowable cost). Therefore, we believe this case is not relevant to the valuation of acquired lease rights.

HCA COMMENT:

Other Medicare principles recognize that the costs of purchased leases are capital expenditures since Medicare regulations disallow reimbursement for costs incurred in connection with leased assets which were not approved by the designated planning agency. This is specifically recognized by 42 CFR §405.435(b) which provides "any costs related to capital expenditures . . . are not allowable where the Secretary has determined that the capital expenditures have not been submitted to the designated planning agency as required . . . - Such principle also applies to the reasonable equivalent of that portion of any rental expense incurred pursuant to a lease or a comparable arrangement . . . but would have been excluded had the provider acquired such a facility or equipment by purchase."

GAO ANALYSIS:

42 C.F.R. 405.435(b) is designed to ensure that providers do not circumvent the prohibition against Medicare payment of capital costs incurred where the construction or improvement of a health facility was not approved under the health facilities planning law. (If a provider was able to claim lease payments, it would represent an indirect payment of unapproved capital expenditures.) In our opinion, this regulation is not relevant to the valuation of acquired lease rights.

HCA COMMENT:

There are also tax principles which support HCA's treatment of its purchased leases which not only control for tax purposes but are relevant for Medicare purposes. The relevant regulation is §1.162-11(a) of the IRS Regulations which allows a purchased leasehold to be amortized over the number of years remaining on the acquired lease. The costs of the leases which are to amortized over the remaining lease term are exclusive of the rental payments required to be paid under the lease. See Zenith Sportswear Co., Inc. v. CIR 28 TC 455 (1957).

GAO ANALYSIS:

The Internal Revenue Service regulation cited permits a lessee to amortize a purchased lease in equal yearly amounts over the remaining life of the lease and to deduct such amount from income for tax purposes. This section does not deal with valuation of acquired lease rights.

HCA COMMENT:

Significantly, other government reimbursement programs, in particular the Defense Acquisition Regulations ("DAR") and the Cost Accounting Standards Board recognize the general application of GAAP to determine allowability of costs. DAR 15-201.2. With respect to the treatment of leases, DAR 15-205.9(j) specifically recognizes the application of FASB Statement No. 13 to treat long-term leased assets as purchased assets.

GAO ANALYSIS:

DAR 15-201.2 provides (as do Medicare guidelines) that GAAP can be used if specific standards for determining costs are not given in the regulation itself. DAR 15-205.9(j) states that Cost Accounting Standard 404 is applicable for assets which are acquired by means of a capital lease as that term is defined in FASB Statement No. 13. Because Medicare does not recognize capital leases or the definition of them in FASB No. 13, the cited regulations are not relevant to Medicare policies.

HCA COMMENT:

In addition to the fundamental misconception regarding the proper treatment of leased assets discussed above, the draft report contains eight erroneous or misleading statements pertaining to the HCA's treatment of its leased facilities which need to be clarified.

1. On page 31, the report implies that HCA failed to identify all its leased hospitals and that the GAO "identified other hospitals with leased assets." This confuses two different categories of leased assets, namely lease of a hospital and lease of movable equipment in a hospital. HCA was not asked to identify movable equipment leases as there was no revaluation of movable equipment acquired from HAI. HCA requests that the final report be corrected on this matter.

GAO ANALYSIS:

We included the information on the leased assets that had been capitalized to show that, in addition to the leased hospitals, other hospitals had also recorded leased assets as if they were owned.

HCA COMMENT:

2. In two places the report implies confusion on the part of HCA with respect to the classification of its leased hospitals as capital or operating leases, indicating

HCA has classified leases as both in different documents (at 31) and that its documents are inconsistent (at 34). In fact, HCA consistently deemed all its leases to be capital leases for financial reporting purposes, in accordance with GAAP. However, due to the peculiar Medicare definition of "virtual purchase" leases in HIM-15 §110B, eight of the fourteen leased hospitals were treated as operating leases for purposes of claiming lease rental expenses rather than ownership costs. The "inconsistency" is due to complex program requirements and the report's statements regarding inconsistency should be deleted.

GAO ANALYSIS:

We noted the following inconsistencies in the classification of leases:

--On HCA's workpaper for Medicare depreciation recapture, Houston International was treated as a virtual purchase, but on the documents HCA sent to its home office intermediary, it was classified as an operating lease.

--On one list of leased hospitals HCA provided to its home office intermediary, Gulf Coast was identified as a leased hospital, but on another list Doctors Memorial-Baton Rouge was shown as leased and Gulf Coast was not included.

--HCA's acquisition audit workpapers state that De Paul Hospital is an operating lease which is being capitalized, whereas on the list of leased hospitals HCA provided to its home office intermediary, it is shown as a virtual purchase.

HCA COMMENT:

3. Again on page 31, the report erroneously states Medicare does not recognize capitalized leases for reimbursement purposes. This is incorrect since the Medicare regulations do address such leases and provide for the manner in which costs will be allowed. See HIM-15 §110B.

GAO ANALYSIS:

Section 110B of HIM-15 does not address capitalized leases but rather discusses the criteria under which a lease-purchase agreement is considered a virtual purchase and, therefore, has rental charges limited to the costs of ownership. These criteria were cited in the draft report during our discussion of virtual purchases.

HCA COMMENT:

4. At page 32, the report states debt associated with the leased facilities quadrupled after the merger. However, the report fails to disclose that a substantial portion of the $215,000,000 of debt related to the leases, $57,000,000, was allocated to goodwill which is, of course, not claimed as a cost. This omission should also be corrected.

GAO ANALYSIS:

In this section we were discussing HCA's accounting records and not its claims for Medicare reimbursement. Therefore, we did not discuss the amount of goodwill included in the total debt assigned to the leased hospitals. We have added a footnote to the table on page 32 indicating that a portion of the debt was allocated by HCA to goodwill.

HCA COMMENT:

5. The report implies that HCA placed "other expenses such as interest, rent expense, lease amortizations and property taxes" under the wrong section of the Medicare cost reports (at 32). In fact, the "Depreciation-Buildings and Fixtures" cost center is the proper section of the cost report under which such costs should be entered, in accordance with Medicare cost reporting guidelines.

GAO ANALYSIS:

We merely pointed out that in Medicare cost reports, more than depreciation is included under the "Depreciation-Building and Fixtures" line item.

HCA COMMENT:

6. HCA is unable to verify the amounts set forth on page 33 of the draft report relating to Doctors Hospital in Little Rock, Arkansas. It appears to HCA, however, that these amounts are overstated.

GAO ANALYSIS:

The substantial increase in claimed capital costs after the acquisition (from $21.27 per inpatient day to $92.34) was taken from Medicare cost reports for the applicable periods.

HCA COMMENT:

7. With respect to the distinction to be made between owned assets and those used under operating leases referred to on page 33, HCA believes a clear distinction already exists for Medicare, financial reporting and tax purposes. As indicated earlier, the confusion appears from the failure to distinguish between valuing a purchased lease and valuing the assets of a leased facility.

GAO ANALYSIS:

As stated in the report, we are questioning HCA's valuation of the acquired lease rights. See pages 31 to 33 for details.

HCA COMMENT:

8. Finally, statements in the draft report regarding the treatment of the lease of Orthopaedic Hospital of Charlotte are erroneous in three respects:

(a) The report correctly states that the hospital filed its cost report for FYE 12/31/80 and claimed interest and depreciation as costs although it should only have claimed rent expense in a lesser amount. It then indicates that although the fiscal intermediary corrected the cost report HCA nevertheless again claimed interest and depreciation in its terminating August 26, 1981 cost report. This necessitated a second intermediary adjustment for the same items. In fact, at the time HCA filed HAI's terminating 8/26/81 cost report, HCA was unaware that the intermediary had reclassified the Charlotte lease from a capital lease for Medicare purposes to an operating lease. Thus, HCA filed the terminating cost report of HAI in the same manner as the prior year's cost report was filed. The intermediary audited both cost years at the same time and it was only at that time that the correct treatment of the lease was brought to HCA's attention.

(b) The report states (at 35) that Orthopaedic Hospital of Charlotte filed its cost report for FYE 2/28/82 erroneously again as a capital lease. This is not correct. In fact, the 1982 cost report was filed showing the lease as an operating lease claiming only lease payments of $228,000 and a portion of the amortized increase in value allocated to Orthopaedic Hospital of Charlotte for the favorable lease acquisition. The total allowable costs claimed amounted to less than $300,000.

(c) The report further states that for FYE 2/28/82 HCA claimed both ownership costs (depreciation and interest) and lease payments. This statement is also wrong for the reasons discussed in (b) above.

Because of the number of errors associated with the description of the cost reports involving Orthopaedic Hospital of Charlotte, HCA suggests that this portion of the draft report be deleted in its entirety in the final report to Representative Gradison.

GAO ANALYSIS:

We discussed this with HCA officials after receiving HCA's comments, and the officials now agree that Orthopaedic claimed allowable costs of $417,610, consisting of $228,296 in lease

payments and $189,314 in interest and depreciation related to acquired lease rights. As discussed on p. 31, we question the value HCA assigned to acquired lease rights, and in this case the intermediary planned to disallow the total claim related to them.

HCA COMMENT:

In summary, the appraisal report's revision was proper and occurred for valid accounting reasons not related to the Medicare program. HCA is not required, as the draft report suggests, to use American Hospital Association useful life guidelines and the appraiser was clearly entitled to use IRS guidelines to value assets - a fact which does not require the company to change its depreciation policies. HCA's practice regarding salvage value is the same as used throughout the industry and has been accepted by fiscal intermediaries for years. Purchased leases were valued (not leased assets) as Medicare and GAAP requires.

IV.

CONCLUSION

If the General Accounting Office has difficulty in verifying numbers or references contained in this response, HCA would be pleased to assist wherever possible. However, in view of the information set forth here, HCA believes that any report issued to Representative Gradison that does not delete the assertions of questionable actions and incorporate the corrections set forth in this response would be improper.

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